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Title 20—Employees' Benefits

(This book contains parts 400 to 499)

Part

CHAPTER III—Social Security Administration 401

CHAPTER III—SOCIAL SECURITY ADMINISTRATION

Part		*Page*
400	[Reserved]	
401	Privacy and disclosure of official records and information	5
402	Availability of information and records to the public	24
404	Federal old-age, survivors and disability insurance (1950–)	41
410	Federal Coal Mine Health and Safety Act of 1969, Title IV—Black lung benefits (1969–)	558
416	Supplemental security income for the aged, blind, and disabled	644
422	Organization and procedures	973
423	Service of process	1001
424–428	[Reserved]	
429	Administrative regulations	1002
430	Personnel	1005
431–497	[Reserved]	
498	Civil monetary penalties, assessments and recommended exclusions	1006
499	[Reserved]	

PART 400 [RESERVED]

PART 401—PRIVACY AND DISCLOSURE OF OFFICIAL RECORDS AND INFORMATION

Subpart A—General

Sec.
401.5 Purpose of the regulations.
401.10 Applicability.
401.15 Limitations on scope.
401.20 Scope.
401.25 Terms defined.

Subpart B—The Privacy Act

401.30 Privacy Act responsibilities.
401.35 Your right to request records.
401.40 How to get your own records.
401.45 Verifying your identity.
401.50 Granting notification of or access to a record.
401.55 Special procedures for notification of or access to medical records.
401.60 Access or notification of program records about two or more individuals.
401.65 How to correct your record.
401.70 Appeals of refusals to correct or amend records.
401.75 Rights of parents or legal guardians.
401.80 Accounting for disclosures.
401.85 Exempt systems.
401.90 Contractors.
401.95 Fees.

Subpart C—Disclosure of Official Records and Information

401.100 Disclosure of records with the consent of the subject of the record.
401.105 Disclosure of personal information without the consent of the subject of the record.
401.110 Disclosure of personal information in nonprogram records without the consent of the subject of the record.
401.115 Disclosure of personal information in program records without the consent of the subject of the record.
401.120 Disclosures required by law.
401.125 Disclosures prohibited by law.
401.130 Freedom of Information Act.
401.135 Other laws.
401.140 General principles.
401.145 Safeguards against unauthorized redisclosure or use.
401.150 Compatible purposes.
401.155 Law enforcement purposes.
401.160 Health or safety.
401.165 Statistical and research activities.
401.170 Congress.
401.175 General Accounting Office.
401.180 Courts.
401.185 Other specific recipients.
401.190 Deceased persons.
401.195 Situations not specified in this part.
401.200 Blood donor locator service.

APPENDIX A TO PART 401—EMPLOYEE STANDARDS OF CONDUCT

AUTHORITY: Secs. 205, 702(a)(5), 1106, and 1141 of the Social Security Act (42 U.S.C. 405, 902(a)(5), 1306, and 1320b–11); 5 U.S.C. 552 and 552a; 8 U.S.C. 1360; 26 U.S.C. 6103; 30 U.S.C. 923.

SOURCE: 62 FR 4143, Jan. 29, 1997, unless otherwise noted.

Subpart A—General

§ 401.5 Purpose of the regulations.

(a) *General.* The purpose of this part is to describe the Social Security Administration (SSA) policies and procedures for implementing the requirements of the Privacy Act of 1974, 5 U.S.C. 552a and section 1106 of the Social Security Act concerning disclosure of information about individuals, both with and without their consent. This part also complies with other applicable statutes.

(b) *Privacy.* This part implements the Privacy Act by establishing agency policies and procedures for the maintenance of records. This part also establishes agency policies and procedures under which you can ask us whether we maintain records about you or obtain access to your records. Additionally, this part establishes policies and procedures under which you may seek to have your record corrected or amended if you believe that your record is not accurate, timely, complete, or relevant.

(c) *Disclosure.* This part also sets out the general guidelines which we follow in deciding whether to make disclosures. However, we must examine the facts of each case separately to decide if we should disclose the information or keep it confidential.

§ 401.10 Applicability.

(a) *SSA.* All SSA employees and components are governed by this part. SSA employees governed by this part include all regular and special government employees of SSA; experts and consultants whose temporary (not in

excess of 1 year) or intermittent services have been procured by SSA by contract pursuant to 5 U.S.C. 3109; volunteers where acceptance of their services are authorized by law; those individuals performing gratuitous services as permitted under conditions prescribed by the Office of Personnel Management; and, participants in work-study or training programs.

(b) *Other entities.* This part also applies to advisory committees and councils within the meaning of the Federal Advisory Committee Act which provide advice to: Any official or component of SSA; or the President and for which SSA has been delegated responsibility for providing services.

§ 401.15 Limitations on scope.

The regulations in this part do not—

(a) Make available to an individual records which are not retrieved by that individual's name or other personal identifier.

(b) Make available to the general public records which are retrieved by an individual's name or other personal identifier or make available to the general public records which would otherwise not be available to the general public under the Freedom of Information Act, 5 U.S.C. 552, and part 402 of this title.

(c) Govern the maintenance or disclosure of, notification about or access to, records in the possession of SSA which are subject to the regulations of another agency, such as personnel records which are part of a system of records administered by the Office of Personnel Management.

(d) Apply to grantees, including State and local governments or subdivisions thereof, administering federally funded programs.

(e) Make available records compiled by SSA in reasonable anticipation of court litigation or formal administrative proceedings. The availability of such records to the general public or to any subject individual or party to such litigation or proceedings shall be governed by applicable constitutional principles, rules of discovery, and applicable regulations of the agency.

§ 401.20 Scope.

(a) *Privacy.* Sections 401.30 through 401.95, which set out SSA's rules for implementing the Privacy Act, apply to all agency records accessed by an individual's name or personal identifier subject to the Privacy Act.

(b) *Disclosure*—(1) *Program records.* Regulations that apply to the disclosure of information about an individual contained in SSA's program records are set out in §§ 401.100 through 401.200 of this part. These regulations also apply to the disclosure of other Federal program information which SSA maintains. That information includes:

(i) Health insurance records which SSA maintains for the Health Care Financing Administration's (HCFA) programs under title XVIII of the Social Security Act. We will disclose these records to HCFA. HCFA may redisclose these records under the regulations applying to records in HCFA's custody;

(ii) Black lung benefit records which SSA maintains for the administration of the Federal Coal Mine Health and Safety Act; (However, this information is not covered by section 1106 of the Social Security Act.) and

(iii) Records kept by consultants. Information retained by a medical, psychological or vocational professional concerning an examination performed under contract in the social security program shall not be disclosed except as permitted by this part.

(2) *Nonprogram records.* Section 401.110 sets out rules applicable to the disclosure of nonprogram records, e.g., SSA's administrative and personnel records.

[62 FR 4143, Jan. 29, 1997, as amended at 65 FR 16812, Mar. 30, 2000]

§ 401.25 Terms defined.

Access means making a record available to a subject individual.

Act means the Social Security Act.

Agency means the Social Security Administration.

Commissioner means the Commissioner of Social Security.

Disclosure means making a record about an individual available to or releasing it to another party.

FOIA means the Freedom of Information Act.

Individual when used in connection with the Privacy Act or for disclosure of nonprogram records, means a living person who is a citizen of the United States or an alien lawfully admitted for permanent residence. It does not include persons such as sole proprietorships, partnerships, or corporations. A business firm which is identified by the name of one or more persons is not an individual. When used in connection with the rules governing program information, *individual* means a living natural person; this does not include corporations, partnerships, and unincorporated business or professional groups of two or more persons.

Information means information about an individual, and includes, but is not limited to, vital statistics; race, sex, or other physical characteristics; earnings information; professional fees paid to an individual and other financial information; benefit data or other claims information; the social security number, employer identification number, or other individual identifier; address; phone number; medical information, including psychological or psychiatric information or lay information used in a medical determination; and information about marital and family relationships and other personal relationships.

Maintain means to establish, collect, use, or disseminate when used in connection with the term *record*; and, to have control over or responsibility for a system of records when used in connection with the term *system of records.*

Notification means communication to an individual whether he is a subject individual. (*Subject individual* is defined further on in this section.)

Program Information means personal information and records collected and compiled by SSA in order to discharge its responsibilities under titles I, II, IV part A, X, XI, XIV, XVI and XVIII of the Act and parts B and C of the Federal Coal Mine Health and Safety Act.

Record means any item, collection, or grouping of information about an individual that is maintained by SSA including, but not limited to, information such as an individual's education, financial transactions, medical history, and criminal or employment history that contains the individual's name, or an identifying number, symbol, or any other means by which an individual can be identified. When used in this part, record means only a record which is in a system of records.

Routine use means the disclosure of a record outside SSA, without the consent of the subject individual, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required to be made by statutes other than the Freedom of Information Act, 5 U.S.C. 552. It does not include disclosures which the Privacy Act otherwise permits without the consent of the subject individual and without regard to whether they are compatible with the purpose for which the information is collected, such as disclosures to the Bureau of the Census, the General Accounting Office, or to Congress.

Social Security Administration (SSA) means (1) that Federal agency which has administrative responsibilities under titles, I, II, X, XI, XIV, XVI, and XVIII of the Act; and (2) units of State governments which make determinations under agreements made under sections 221 and 1633 of the Act.

Social Security program means any program or provision of law which SSA is responsible for administering, including the Freedom of Information Act and Privacy Act. This includes our responsibilities under parts B and C of the Federal Coal Mine Health and Safety Act.

Statistical record means a record maintained for statistical research or reporting purposes only and not maintained to make determinations about a particular subject individual.

Subject individual means the person to whom a record pertains.

System of records means a group of records under our control from which information about an individual is retrieved by the name of the individual or by an identifying number, symbol, or other identifying particular. Single records or groups of records which are not retrieved by a personal identifier are not part of a system of records. Papers maintained by individual Agency employees which are prepared, maintained, or discarded at the discretion of the employee and which are not subject to the Federal Records Act, 44 U.S.C. 2901, are not part of a system of

records; provided, that such personal papers are not used by the employee or the Agency to determine any rights, benefits, or privileges of individuals.

We and *our* mean the Social Security Administration.

Subpart B—The Privacy Act

§ 401.30 Privacy Act responsibilities.

(a) *Policy*. Our policy is to protect the privacy of individuals to the fullest extent possible while nonetheless permitting the exchange of records required to fulfill our administrative and program responsibilities, and responsibilities for disclosing records which the general public is entitled to have under the Freedom of Information Act, 5 U.S.C. 552, and 20 CFR part 402.

(b) *Maintenance of Records.* We will maintain no record unless:

(1) It is relevant and necessary to accomplish an SSA function which is required to be accomplished by statute or Executive Order;

(2) We obtain the information in the record, as much as it is practicable, from the subject individual if we may use the record to determine an individual's rights, benefits or privileges under Federal programs;

(3) We inform the individual providing the record to us of the authority for our asking him or her to provide the record (including whether providing the record is mandatory or voluntary, the principal purpose for maintaining the record, the routine uses for the record, and what effect his or her refusal to provide the record may have on him or her). Further, the individual agrees to provide the record, if the individual is not required by statute or Executive Order to do so.

(c) *First Amendment rights.* We will keep no record which describes how an individual exercises rights guaranteed by the First Amendment unless we are expressly authorized:

(1) By statute,

(2) By the subject individual, or

(3) Unless pertinent to and within the scope of an authorized law enforcement activity.

§ 401.35 Your right to request records.

The Privacy Act gives you the right to direct access to most records about yourself that are in our systems of records. Exceptions to this Privacy Act right include—

(a) Special procedures for access to certain medical records (see 5 U.S.C. 552a(f)(3) and § 401.55);

(b) Unavailability of certain criminal law enforcement records (see 5 U.S.C. 552a(k), and § 401.85); and

(c) Unavailability of records compiled in reasonable anticipation of a court action or formal administrative proceeding.

NOTE TO § 401.35: The Freedom of Information Act (see 20 CFR part 402) allows you to request information from SSA whether or not it is in a system of records.

§ 401.40 How to get your own records.

(a) *Your right to notification and access.* Subject to the provisions governing medical records in § 401.55, you may ask for notification of or access to any record about yourself that is in an SSA system of records. If you are a minor, you may get information about yourself under the same rules as for an adult. Under the Privacy Act, if you are the parent or guardian of a minor, or the legal guardian of someone who has been declared legally incompetent, and you are acting on his or her behalf, you may ask for information about that individual. You may be accompanied by another individual of your choice when you request access to a record in person, *provided* that you affirmatively authorize the presence of such other individual during any discussion of a record to which you are requesting access.

(b) *Identifying the records.* At the time of your request, you must specify which systems of records you wish to have searched and the records to which you wish to have access. You may also request copies of all or any such records. Also, we may ask you to provide sufficient particulars to enable us to distinguish between records on individuals with the same name. The necessary particulars are set forth in the notices of systems of records which are published in the FEDERAL REGISTER.

(c) *Requesting notification or access.* To request notification of or access to a record, you may visit your local social security office or write to the manager of the SSA system of records. The

name and address of the manager of the system is part of the notice of systems of records. Every local social security office keeps a copy of the FEDERAL REGISTER containing that notice. That office can also help you get access to your record. You do not need to use any special form to ask for a record about you in our files, but your request must give enough identifying information about the record you want to enable us to find your particular record. This identifying information should include the system of records in which the record is located and the name and social security number (or other identifier) under which the record is filed. We do not honor requests for all records, all information, or similar blanket requests. Before granting notification of or access to a record, we may, if you are making your request in person, require you to put your request in writing if you have not already done so.

§401.45 Verifying your identity.

(a) *When required.* Unless you are making a request for notification of or access to a record in person, and you are personally known to the SSA representative, you must verify your identity in accordance with paragraph (b) of this section if:

(1) You make a request for notification of a record and we determine that the mere notice of the existence of the record would be a clearly unwarranted invasion of privacy if disclosed to someone other than the subject individual; or,

(2) You make a request for access to a record which is not required to be disclosed to the general public under the Freedom of Information Act, 5 U.S.C. 552, and part 402 of this chapter.

(b) *Manner of verifying identity*—(1) *Request in person.* If you make a request to us in person, you must provide at least one piece of tangible identification such as a driver's license, passport, alien or voter registration card, or union card to verify your identity. If you do not have identification papers to verify your identity, you must certify in writing that you are the individual who you claim to be and that you understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense.

(2) *Request by telephone.* If you make a request by telephone, you must verify your identity by providing identifying particulars which parallel the record to which notification or access is being sought. If we determine that the particulars provided by telephone are insufficient, you will be required to submit your request in writing or in person. We will not accept telephone requests where an individual is requesting notification of or access to sensitive records such as medical records.

(3) *Requests not in person.* Except as provided in paragraph (b)(2) of this section, if you do not make a request in person, you must submit a notarized request to SSA to verify your identity or you must certify in your request that you are the individual you claim to be and that you understand that the knowing and willful request for or acquisition of a record pertaining to an individual under false pretenses is a criminal offense.

(4) *Requests on behalf of another.* If you make a request on behalf of a minor or legal incompetent as authorized under §401.40, you must verify your relationship to the minor or legal incompetent, in addition to verifying your own identity, by providing a copy of the minor's birth certificate, a court order, or other competent evidence of guardianship to SSA; except that you are not required to verify your relationship to the minor or legal incompetent when you are not required to verify your own identity or when evidence of your relationship to the minor or legal incompetent has been previously given to SSA.

(5) *Medical records—additional verification.* You need to further verify your identity if you are requesting notification of or access to sensitive records such as medical records. Any information for further verification must parallel the information in the record to which notification or access is being sought. Such further verification may include such particulars as the date or place of birth, names of parents, name of employer or the specific times the individual received medical treatment.

§ 401.50 Granting notification of or access to a record.

(a) *General.* Subject to the provisions governing medical records in § 401.55 and the provisions governing exempt systems in § 401.85, upon receipt of your request for notification of or access to a record and verification of your identity, we will review your request and grant notification or access to a record, if you are the subject of the record.

(b) *Our delay in responding.* If we determine that we will have to delay responding to your request because of the number of requests we are processing, a breakdown of equipment, shortage of personnel, storage of records in other locations, etc., we will so inform you and tell you when notification or access will be granted.

§ 401.55 Special procedures for notification of or access to medical records.

(a) *General.* In general, you have a right to notification of or access to your medical records, including psychological records, as well as to other records pertaining to you that we maintain. In this section, we set forth special procedures as permitted by the Privacy Act for notification of or access to medical records, including a special procedure for notification of or access to medical records of minors.

(b) *Medical records procedures*—(1) *Notification of or access to medical records.* (i) You may request notification of or access to a medical record pertaining to you. Unless you are a parent or guardian requesting notification of or access to a minor's medical record, you must make a request for a medical record in accordance with this section and the procedures in §§ 401.45 through 401.50 of this part.

(ii) When you request medical information about yourself, you must also name a representative in writing. The representative may be a physician, other health professional, or other responsible individual who would be willing to review the record and inform you of its contents at your representative's discretion. If you do not designate a representative, we may decline to release the requested information. In some cases, it may be possible to release medical information directly to you rather than to your representative.

(2) *Utilization of the designated representative.* You will be granted direct access to your medical record if we can determine that direct access is not likely to have an adverse effect on you. If we believe that we are not qualified to determine, or if we do determine, that direct access to you is likely to have an adverse effect, the record will be sent to the designated representative. We will inform you in writing that the record has been sent.

(c) *Medical records of minors*—(1) *Requests by minors; notification of or access to medical records to minors.* A minor may request notification of or access to a medical record pertaining to him or her in accordance with paragraph (b) of this section.

(2) *Requests on a minor's behalf; notification of or access to medical records to an individual on a minor's behalf.* (i) To protect the privacy of a minor, we will not give to a parent or guardian direct notification of or access to a minor's record, even though the parent or guardian who requests such notification or access is authorized to act on a minor's behalf as provided in § 401.75 of this part.

(ii) A parent or guardian must make all requests for notification of or access to a minor's medical record in accordance with this paragraph and the procedures in §§ 401.45 through 401.50 of this part. A parent or guardian must at the time he or she makes a request designate a family physician or other health professional (other than a family member) to whom the record, if any, will be sent. If the parent or guardian will not designate a representative, we will decline to release the requested information.

(iii) Where a medical record on the minor exists, we will in all cases send it to the physician or health professional designated by the parent or guardian. If disclosure of the record would constitute an invasion of the minor's privacy, we will bring that fact to the attention of the physician or health professional to whom we send the record. We will ask the physician or health professional to consider the effect that disclosure of the record to

the parent or guardian would have on the minor when the physician or health professional determines whether the minor's medical record should be made available to the parent or guardian. We will respond in substantially the following form to the parent or guardian making the request:

We have completed processing your request for notification of or access to 's (Name of minor) medical records. Please be informed that if any medical record was found pertaining to that individual, it has been sent to your designated physician or health professional.

(iv) In each case where we send a minor's medical record to a physician or health professional, we will make reasonable efforts to inform the minor that we have given the record to the representative.

(d) *Requests on behalf of an incapacitated adult.* If you are the legal guardian of an adult who has been declared legally incompetent, you may receive his or her records directly.

§401.60 Access or notification of program records about two or more individuals.

When information about two or more individuals is in one record filed under your social security number, you may receive the information about you and the fact of entitlement and the amount of benefits payable to other persons based on your record. You may receive information about yourself or others, which is filed under someone else's social security number, if that information affects your entitlement to social security benefits or the amount of those benefits.

§401.65 How to correct your record.

(a) *How to request a correction.* This section applies to all records kept by SSA (as described in §401.5) except for records of earnings. (20 CFR 422.125 describes how to request correction of your earnings record.) You may request that your record be corrected or amended if you believe that the record is not accurate, timely, complete, relevant, or necessary to the administration of a social security program. To amend or correct your record, you should write to the manager identified in the notice of systems of records which is published in the FEDERAL REGISTER (see §401.40(c) on how to locate this information). The staff at any social security office can help you prepare the request. You should submit any available evidence to support your request. Your request should indicate—

(1) The system of records from which the record is retrieved;

(2) The particular record which you want to correct or amend;

(3) Whether you want to add, delete or substitute information in the record; and

(4) Your reasons for believing that your record should be corrected or amended.

(b) *What we will not change.* You cannot use the correction process to alter, delete, or amend information which is part of a determination of fact or which is evidence received in the record of a claim in the administrative appeal process. Disagreements with these determinations are to be resolved through the SSA appeal process. (See subparts I and J of part 404, and subpart N of part 416, of this chapter.) For example, you cannot use the correction process to alter or delete a document showing a birth date used in deciding your social security claim. However, you may submit a statement on why you think certain information should be altered, deleted, or amended, and we will make this statement part of your file.

(c) *Acknowledgment of correction request.* We will acknowledge receipt of a correction request within 10 working days, unless we can review and process the request and give an initial determination of denial or compliance before that time.

(d) *Notice of error.* If the record is wrong, we will correct it promptly. If wrong information was disclosed from the record, we will tell all those of whom we are aware received that information that it was wrong and will give them the correct information. This will not be necessary if the change is not due to an error, e.g., a change of name or address.

(e) *Record found to be correct.* If the record is correct, we will inform you in writing of the reason why we refuse to amend your record and we will also inform you of your right to seek a review

of the refusal and the name and address of the official to whom you should send your request for review.

(f) *Record of another government agency.* If you request us to correct or amend a record governed by the regulation of another government agency, e.g., Office of Personnel Management, Federal Bureau of Investigation, we will forward your request to such government agency for processing and we will inform you in writing of the referral.

§ 401.70 Appeals of refusals to correct or amend records.

(a) *Which decisions are covered.* This section describes how to appeal a decision made under the Privacy Act concerning your request for correction of a record or for access to your records, those of your minor child, or those of a person for whom you are the legal guardian. We generally handle a denial of your request for information about another person under the provisions of the FOIA (see part 402 of this chapter). This section applies only to written requests.

(b) *Appeal of refusal to amend or correct a record.* (1) If we deny your request to correct a record, you may request a review of that decision. As discussed in § 401.65(e), our letter denying your request will tell you to whom to write.

(2) We will review your request within 30 working days from the date of receipt. However, for a good reason and with the approval of the Commissioner, or designee, this time limit may be extended up to an additional 30 days. In that case, we will notify you about the delay, the reason for it, and the date when the review is expected to be completed. If, after review, we determine that the record should be corrected, the record will be corrected. If, after review, we also refuse to amend the record exactly as you requested, we will inform you—

(i) That your request has been refused and the reason;

(ii) That this refusal is SSA's final decision;

(iii) That you have a right to seek court review of this request to amend the record; and

(iv) That you have a right to file a statement of disagreement with the decision. Your statement should include the reason you disagree. We will make your statement available to anyone to whom the record is subsequently disclosed, together with a statement of our reasons for refusing to amend the record. Also, we will provide a copy of your statement to individuals whom we are aware received the record previously.

(c) *Appeals after denial of access.* If, under the Privacy Act, we deny your request for access to your own record, those of your minor child, or those of a person for whom you are the legal guardian, we will advise you in writing of the reason for that denial, the name and title or position of the person responsible for the decision, and your right to appeal that decision. You may appeal the denial decision to the Commissioner of Social Security, 6401 Security Boulevard, Baltimore, MD 21235, within 30 days after you receive the notice denying all or part of your request, or, if later, within 30 days after you receive materials sent to you in partial compliance with your request. If we refuse to release a medical record because you did not designate a representative (§ 401.55) to receive the material, that refusal is not a formal denial of access and, therefore, may not be appealed to the Commissioner. If you file an appeal, either the Commissioner or a designee will review your request and any supporting information submitted and then send you a notice explaining the decision on your appeal. We must make our decision within 20 working days after we receive your appeal. The Commissioner or a designee may extend this time limit up to 10 additional working days if one of the circumstances in 20 CFR 402.140 is met. We will notify you in writing of any extension, the reason for the extension, and the date by which we will decide your appeal. The notice of the decision on your appeal will explain your right to have the matter reviewed in a Federal district court if you disagree with all or part of our decision.

§ 401.75 Rights of parents or legal guardians.

For purposes of this part, a parent or guardian of any minor or the legal guardian of any individual who has

been declared incompetent due to physical or mental incapacity or age by a court of competent jurisdiction is authorized to act on behalf of a minor or incompetent individual. Except as provided in §401.45, governing procedures for verifying an individual's identity, and §401.55(c) governing special procedures for notification of or access to a minor's medical records, if you are authorized to act on behalf of a minor or legal incompetent, you will be viewed as if you were the individual or subject individual.

§401.80 Accounting for disclosures.

(a) We will maintain an accounting of all disclosures of a record for five years or for the life of the record, whichever is longer; *except that*, we will not make accounting for:

(1) Disclosures under paragraphs (a) and (b) of §401.110; and,

(2) Disclosures of your record made with your written consent.

(b) The accounting will include:

(1) The date, nature, and purpose of each disclosure; and

(2) The name and address of the person or entity to whom the disclosure is made.

(c) You may request access to an accounting of disclosures of your record. You must request access to an accounting in accordance with the procedures in §401.40. You will be granted access to an accounting of the disclosures of your record in accordance with the procedures of this part which govern access to the related record. We may, at our discretion, grant access to an accounting of a disclosure of a record made under paragraph (g) of §401.110.

§401.85 Exempt systems.

(a) *General policy*. The Privacy Act permits certain types of specific systems of records to be exempt from some of its requirements. Our policy is to exercise authority to exempt systems of records only in compelling cases.

(b) *Specific systems of records exempted*. (1) Those systems of records listed in paragraph (b)(2) of this section are exempt from the following provisions of the Act and this part:

(i) 5 U.S.C. 552a(c)(3) and paragraph (c) of §401.80 of this part which require that you be granted access to an accounting of disclosures of your record.

(ii) 5 U.S.C. 552a (d) (1) through (4) and (f) and §§401.35 through 401.75 relating to notification of or access to records and correction or amendment of records.

(iii) 5 U.S.C. 552a(e)(4) (G) and (H) which require that we include information about SSA procedures for notification, access, and correction or amendment of records in the notice for the systems of records.

(iv) 5 U.S.C. 552a(e)(3) and §401.30 which require that if we ask you to provide a record to us, we must inform you of the authority for our asking you to provide the record (including whether providing the record is mandatory or voluntary, the principal purposes for maintaining the record, the routine uses for the record, and what effect your refusal to provide the record may have on you), and if you are not required by statute or Executive Order to provide the record, that you agree to provide the record. This exemption applies only to an investigatory record compiled by SSA for criminal law enforcement purposes in a system of records exempt under subsection (j)(2) of the Privacy Act to the extent that these requirements would prejudice the conduct of the investigation.

(2) The following systems of records are exempt from those provisions of the Privacy Act and this part listed in paragraph (b)(1) of this section:

(i) Pursuant to subsection (j)(2) of the Privacy Act, the Investigatory Material Compiled for Law Enforcement Purposes System, SSA.

(ii) Pursuant to subsection (k)(2) of the Privacy Act:

(A) The General Criminal Investigation Files, SSA;

(B) The Criminal Investigations File, SSA; and,

(C) The Program Integrity Case Files, SSA.

(D) Civil and Administrative Investigative Files of the Inspector General, SSA/OIG.

(E) Complaint Files and Log. SSA/OGC.

(iii) Pursuant to subsection (k)(5) of the Privacy Act:

(A) The Investigatory Material Compiled for Security and Suitability Purposes System, SSA; and,

(B) The Suitability for Employment Records, SSA.

(iv) Pursuant to subsection (k)(6) of the Privacy Act, the Personnel Research and Merit Promotion Test Records, SSA/DCHR/OPE.

(c) *Notification of or access to records in exempt systems of records.* (1) Where a system of records is exempt as provided in paragraph (b) of this section, you may nonetheless request notification of or access to a record in that system. You should make requests for notification of or access to a record in an exempt system of records in accordance with the procedures of §§ 401.35 through 401.55.

(2) We will grant you notification of or access to a record in an exempt system but only to the extent such notification or access would not reveal the identity of a source who furnished the record to us under an express promise, and prior to September 27, 1975, an implied promise, that his or her identity would be held in confidence, if:

(i) The record is in a system of records which is exempt under subsection (k)(2) of the Privacy Act and you have been, as a result of the maintenance of the record, denied a right, privilege, or benefit to which you would otherwise be eligible; or,

(ii) The record is in a system of records which is exempt under subsection (k)(5) of the Privacy Act.

(3) If we do not grant you notification of or access to a record in a system of records exempt under subsections (k) (2) and (5) of the Privacy Act in accordance with this paragraph, we will inform you that the identity of a confidential source would be revealed if we granted you notification of or access to the record.

(d) *Discretionary actions by SSA.* Unless disclosure of a record to the general public is otherwise prohibited by law, we may at our discretion grant notification of or access to a record in a system of records which is exempt under paragraph (b) of this section. Discretionary notification of or access to a record in accordance with this paragraph will not be a precedent for discretionary notification of or access to a similar or related record and will not obligate us to exercise discretion to grant notification of or access to any other record in a system of records which is exempt under paragraph (b) of this section.

§ 401.90 Contractors.

(a) All contracts which require a contractor to maintain, or on behalf of SSA to maintain, a system of records to accomplish an SSA function must contain a provision requiring the contractor to comply with the Privacy Act and this part.

(b) A contractor and any employee of such contractor will be considered employees of SSA only for the purposes of the criminal penalties of the Privacy Act, 5 U.S.C. 552a(i), and the employee standards of conduct (see appendix A of this part) where the contract contains a provision requiring the contractor to comply with the Privacy Act and this part.

(c) This section does not apply to systems of records maintained by a contractor as a result of his management discretion, e.g., the contractor's personnel records.

§ 401.95 Fees.

(a) *Policy.* Where applicable, we will charge fees for copying records in accordance with the schedule set forth in this section. We may only charge fees where you request that a copy be made of the record to which you are granted access. We will not charge a fee for searching a system of records, whether the search is manual, mechanical, or electronic. Where we must copy the record in order to provide access to the record (e.g., computer printout where no screen reading is available), we will provide the copy to you without cost. Where we make a medical record available to a representative designated by you or to a physician or health professional designated by a parent or guardian under § 401.55 of this part, we will not charge a fee.

(b) *Fee schedule.* Our Privacy Act fee schedule is as follows:

(1) Copying of records susceptible to photocopying—$.10 per page.

(2) Copying records not susceptible to photocopying (e.g., punch cards or

magnetic tapes)—at actual cost to be determined on a case-by-case basis.

(3) We will not charge if the total amount of copying does not exceed $25.

(c) *Other Fees.* We also follow §§ 402.155 through 402.165 of this chapter to determine the amount of fees, if any, we will charge for providing information under the FOIA and Privacy Act.

Subpart C—Disclosure of Official Records and Information

§ 401.100 Disclosure of records with the consent of the subject of the record.

(a) Except as permitted by the Privacy Act and the regulations in this chapter, or if required by the FOIA, we will not disclose your record without your written consent. The consent must specify the individual, organizational unit or class of individuals or organizational units to whom the record may be disclosed, which record may be disclosed and, where applicable, during which time frame the record may be disclosed (e.g., during the school year, while the subject individual is out of the country, whenever the subject individual is receiving specific services). We will not honor a blanket consent to disclose all your records to unspecified individuals or organizational units. We will verify your identity and, where applicable (e.g., where you consent to disclosure of a record to a specific individual), the identity of the individual to whom the record is to be disclosed.

(b) A parent or guardian of a minor is not authorized to give consent to a disclosure of the minor's medical record. See § 401.55(c) for the procedures for disclosures of or access to the medical records of minors.

§ 401.105 Disclosure of personal information without the consent of the subject of the record.

(a) SSA maintains two categories of records which contain personal information:

(1) Nonprogram records, primarily administrative and personnel records which contain information about SSA's activities as a government agency and employer, and

(2) Program records which contain information about SSA's clients that it keeps to administer benefit programs under Federal law.

(b) We apply different levels of confidentiality to disclosures of information in the categories in paragraphs (a)(1) and (2) of this section. For administrative and personnel records, we apply the Privacy Act restrictions on disclosure. For program records, we apply somewhat more strict confidentiality standards than those found in the Privacy Act. The reason for this difference in treatment is that our program records include information about a much greater number of persons than our administrative records, the information we must collect for program purposes is often very sensitive, and claimants are required by statute and regulation to provide us with the information in order to establish entitlement for benefits.

§ 401.110 Disclosure of personal information in nonprogram records without the consent of the subject of the record.

The disclosures listed in this section may be made from our nonprogram records, e.g., administrative and personnel records, without your consent. Such disclosures are those:

(a) To officers and employees of SSA who have a need for the record in the performance of their duties. The SSA official who is responsible for the record may upon request of any officer or employee, or on his own initiative, determine what constitutes legitimate need.

(b) Required to be disclosed under the Freedom of Information Act, 5 U.S.C. 552, and 20 CFR part 402.

(c) For a routine use as defined in § 401.25 of this part. Routine uses will be listed in any notice of a system of records. SSA publishes notices of systems of records, including all pertinent routine uses, in the FEDERAL REGISTER.

(d) To the Bureau of the Census for purposes of planning or carrying out a census or survey or related activity pursuant to the provisions of Title 13 U.S.C.

(e) To a recipient who has provided us with advance written assurance that

the record will be used solely as a statistical research or reporting record; *Provided,* that, the record is transferred in a form that does not identify the subject individual.

(f) To the National Archives of the United States as a record which has sufficient historical or other value to warrant its continued preservation by the United States Government, or for evaluation by the Administrator of General Services or his designee to determine whether the record has such value.

(g) To another government agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the head of such government agency or instrumentality has submitted a written request to us, specifying the record desired and the law enforcement activity for which the record is sought.

(h) To an individual pursuant to a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last known address of the subject individual.

(i) To either House of Congress, or to the extent of matter within its jurisdiction, any committee or subcommittee thereof, any joint committee of Congress or subcommittee of any such joint committee.

(j) To the Comptroller General, or any of his authorized representatives, in the course of the performance of the duties of the General Accounting Office.

(k) Pursuant to the order of a court of competent jurisdiction.

§ 401.115 Disclosure of personal information in program records without the consent of the subject of the record.

This section describes how various laws control the disclosure or confidentiality of personal information which we keep. We must consider these laws in the following order:

(a) Some laws require us to disclose information (§ 401.120); some laws require us to withhold information (§ 401.125). These laws control whenever they apply.

(b) If no law of this type applies in a given case, then we must look to FOIA principles. See § 401.130.

(c) When FOIA principles do not require disclosure, we may disclose information if both the Privacy Act and section 1106 of the Social Security Act permit the disclosure.

§ 401.120 Disclosures required by law.

We disclose information when a law specifically requires it. The Social Security Act requires us to disclose information for certain program purposes. These include disclosures to the SSA Office of Inspector General, the Federal Parent Locator Service, and to States pursuant to an arrangement regarding use of the Blood Donor Locator Service. Also, there are other laws which require that we furnish other agencies information which they need for their programs. These agencies include the Department of Veterans Affairs for its benefit programs, the Immigration and Naturalization Service to carry out its duties regarding aliens, the Railroad Retirement Board for its benefit programs, and to Federal, State, and local agencies administering Aid to Families with Dependent Children, Medicaid, unemployment compensation, food stamps, and other programs.

§ 401.125 Disclosures prohibited by law.

We do not disclose information when a law specifically prohibits it. The Internal Revenue Code generally prohibits us from disclosing tax return information which we receive to maintain individual earnings records. This includes, for example, amounts of wages and contributions from employers. Other laws restrict our disclosure of certain information about drug and alcohol abuse which we collect to determine eligibility for social security benefits.

§ 401.130 Freedom of Information Act.

The FOIA requires us to disclose any information in our records upon request from the public, unless one of several exemptions in the FOIA applies. When the FOIA requires disclosure (see part 402 of this chapter), the Privacy Act permits it. *The public* does not include Federal agencies, courts, or

the Congress, but does include State agencies, individuals, corporations, and most other parties. The FOIA does not apply to requests that are not from *the public* (e.g., from a Federal agency). However, we apply FOIA principles to requests from these other sources for disclosure of program information.

§ 401.135 Other laws.

When the FOIA does not apply, we may not disclose any personal information unless both the Privacy Act and section 1106 of the Social Security Act permit the disclosure. Section 1106 of the Social Security Act requires that disclosures which may be made must be set out in statute or regulations; therefore, any disclosure permitted by this part is permitted by section 1106.

§ 401.140 General principles.

When no law specifically requiring or prohibiting disclosure applies to a question of whether to disclose information, we follow FOIA principles to resolve that question. We do this to insure uniform treatment in all situations. The FOIA principle which most often applies to SSA disclosure questions is whether the disclosure would result in a ''clearly unwarranted invasion of personal privacy.'' To decide whether a disclosure would be a clearly unwarranted invasion of personal privacy we consider—

(a) The sensitivity of the information (e.g., whether individuals would suffer harm or embarrassment as a result of the disclosure);

(b) The public interest in the disclosure;

(c) The rights and expectations of individuals to have their personal information kept confidential;

(d) The public's interest in maintaining general standards of confidentiality of personal information; and

(e) The existence of safeguards against unauthorized redisclosure or use.

§ 401.145 Safeguards against unauthorized redisclosure or use.

(a) The FOIA does not authorize us to impose any restrictions on how information is used after we disclose it under that law. In applying FOIA principles, we consider whether the information will be adequately safeguarded against improper use or redisclosure. We must consider all the ways in which the recipient might use the information and how likely the recipient is to redisclose the information to other parties. Thus, before we disclose personal information we may consider such factors as—

(1) Whether only those individuals who have a need to know the information will obtain it;

(2) Whether appropriate measures to safeguard the information to avoid unwarranted use or misuse will be taken; and

(3) Whether we would be permitted to conduct on-site inspections to see whether the safeguards are being met.

(b) We feel that there is a strong public interest in sharing information with other agencies with programs having the same or similar purposes, so we generally share information with those agencies. However, since there is usually little or no public interest in disclosing information for disputes between two private parties or for other private or commercial purposes, we generally do not share information for these purposes.

§ 401.150 Compatible purposes.

(a) *General.* The Privacy Act allows us to disclose information, without the consent of the individual, to any other party for routine uses.

(b) *Routine use.* We publish notices of systems of records in the FEDERAL REGISTER which contain a list of all *routine use* disclosures.

(c) *Determining compatibility*. We disclose information for routine uses where necessary to carry out SSA's programs. It is also our policy to disclose information for use in other programs which have the same purposes as SSA programs if the information concerns eligibility, benefit amounts, or other matters of benefit status in a social security program and is relevant to determining the same matters in the other program. For example, we disclose information to the Railroad Retirement Board for pension and unemployment compensation programs, to the Veterans Administration for its benefit program, to worker's compensation programs, to State general

assistance programs, and to other income maintenance programs at all levels of government; we also disclose for health-maintenance programs like Medicare and Medicaid, and in appropriate cases, for epidemiological and similar research.

§ 401.155 Law enforcement purposes.

(a) *General.* The Privacy Act allows us to disclose information for law enforcement purposes under certain conditions. Much of the information in our files is especially sensitive or very personal. Furthermore, participation in social security programs is mandatory, so people cannot limit what information is given to us. Therefore, we generally disclose information for law enforcement purposes only in limited situations. Paragraphs (b) and (c) of this section discuss the disclosures we generally make for these purposes.

(b) *Serious crimes.* SSA may disclose information for criminal law enforcement purposes where a violent crime such as murder or kidnapping has been committed and the individual about whom the information is being sought has been indicted or convicted of that crime. The Privacy Act allows us to disclose if the head of the law enforcement agency makes a written request giving enough information to show that these conditions are met, what information is needed, and why it is needed.

(c) *Criminal activity involving the social security program or another program with the same purposes.* We disclose information when necessary to investigate or prosecute fraud or other criminal activity involving the social security program. We may also disclose information for investigation or prosecution of criminal activity in other income-maintenance or health-maintenance programs (e.g., other governmental pension programs, unemployment compensation, general assistance, Medicare or Medicaid) if the information concerns eligibility, benefit amounts, or other matters of benefit status in a social security program and is relevant to determining the same matters in the other program.

§ 401.160 Health or safety.

The Privacy Act allows us to disclose information in compelling circumstances where an individual's health or safety is affected. For example, if we learn that someone has been exposed to an excessive amount of radiation, we may notify that person and appropriate health officials. If we learn that someone has made a threat against someone else, we may notify that other person and law enforcement officials. When we make these disclosures, the Privacy Act requires us to send a notice of the disclosure to the last known address of the person whose record was disclosed.

§ 401.165 Statistical and research activities.

(a) *General.* Statistical and research activities often do not require information in a format that identifies specific individuals. Therefore, whenever possible, we release information for statistical or research purposes only in the form of aggregates or individual data that cannot be associated with a particular individual. The Privacy Act allows us to release records if there are safeguards that the record will be used solely as a statistical or research record and the individual cannot be identified from any information in the record.

(b) *Safeguards for disclosure with identifiers.* The Privacy Act also allows us to disclose data for statistical and research purposes in a form allowing individual identification, pursuant to published routine use, when the purpose is compatible with the purpose for which the record was collected. We will disclose personally identifiable information for statistical and research purposes if—

(1) We determine that the requestor needs the information in an identifiable form for a statistical or research activity, will use the information only for that purpose, and will protect individuals from unreasonable and unwanted contacts;

(2) The activity is designed to increase knowledge about present or alternative social security programs or

other Federal or State income-maintenance or health-maintenance programs, or consists of epidemiological or similar research; and

(3) The recipient will keep the information as a system of statistical records, will follow appropriate safeguards, and agrees to our on-site inspection of those safeguards so we can be sure the information is used or redisclosed only for statistical or research purposes. No redisclosure of the information may be made without SSA's approval.

(c) *Statistical record.* A statistical record is a record in a system of records which is maintained only for statistical and research purposes, and which is not used to make any determination about an individual. We maintain and use statistical records only for statistical and research purposes. We may disclose a statistical record if the conditions in paragraph (b) of this section are met.

(d) *Compiling of records.* Where a request for information for statistical and research purposes would require us to compile records, and doing that would be administratively burdensome to ongoing SSA operations, we may decline to furnish the information.

§ 401.170 Congress.

(a) We disclose information to either House of Congress. We also disclose information to any committee or subcommittee of either House, or to any joint committee of Congress or subcommittee of that committee, if the information is on a matter within the committee's or subcommittee's jurisdiction.

(b) We disclose to any member of Congress the information needed to respond to constituents' requests for information about themselves (including requests from parents of minors, or legal guardians). However, these disclosures are subject to the restrictions in §§ 401.35 through 401.60.

§ 401.175 General Accounting Office.

We disclose information to the General Accounting Office when that agency needs the information to carry out its duties.

§ 401.180 Courts.

(a) *General.* The Privacy Act allows us to disclose information when we receive an order from a court of competent jurisdiction. However, much of our information is especially sensitive. Participation in social security programs is mandatory, and so people cannot limit what information is given to SSA. When information is used in a court proceeding, it usually becomes part of a public record, and its confidentiality cannot be protected. Therefore, we treat subpoenas or other court orders for information under the rules in paragraph (b) of this section.

(b) *Subpoena.* We generally disclose information in response to a subpoena or other court order if—

(1) Another section of this part would specifically allow the release; or

(2) The Commissioner of SSA is a party to the proceeding; or

(3) The information is necessary for due process in a criminal proceeding. In other cases, we try to satisfy the needs of courts while preserving the confidentiality of information.

§ 401.185 Other specific recipients.

In addition to disclosures we make under the routine use provision, we also release information to—

(a) The Bureau of the Census for purposes of planning or carrying out a census, survey, or related activity; and

(b) The National Archives of the United States if the record has sufficient historical or other value to warrant its continued preservation by the United States Government. We also disclose a record to the Administrator of General Services for a determination of whether the record has such a value.

§ 401.190 Deceased persons.

We do not consider the disclosure of information about a deceased person to be a clearly unwarranted invasion of that person's privacy. However, in disclosing information about a deceased person, we follow the principles in § 401.115 to insure that the privacy rights of a living person are not violated.

§ 401.195 Situations not specified in this part.

If no other provision in this part specifically allows SSA to disclose information, the Commissioner or designee may disclose this information if not prohibited by Federal law. For example, the Commissioner or designee may disclose information necessary to respond to life threatening situations.

§ 401.200 Blood donor locator service.

(a) *General.* We will enter into arrangements with State agencies under which we will furnish to them at their request the last known personal mailing addresses (residence or post office box) of blood donors whose blood donations show that they are or may be infected with the human immunodeficiency virus which causes acquired immune deficiency syndrome. The State agency or other authorized person, as defined in paragraph (b) of this section, will then inform the donors that they may need medical care and treatment. The safeguards that must be used by authorized persons as a condition to receiving address information from the Blood Donor Locator Service are in paragraph (g) of this section, and the requirements for a request for address information are in paragraph (d) of this section.

(b) *Definitions. State* means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Commonwealth of Northern Marianas, and the Trust Territory of the Pacific Islands.

Authorized person means—

(1) Any agency of a State (or of a political subdivision of a State) which has duties or authority under State law relating to the public health or otherwise has the duty or authority under State law to regulate blood donations; and

(2) Any entity engaged in the acceptance of blood donations which is licensed or registered by the Food and Drug Administration in connection with the acceptance of such blood donations, and which provides for—

(i) The confidentiality of any address information received pursuant to the rules in this part and section 1141 of the Social Security Act and related blood donor records;

(ii) Blood donor notification procedures for individuals with respect to whom such information is requested and a finding has been made that they are or may be infected with the human immunodeficiency virus; and

(iii) Counseling services for such individuals who have been found to have such virus. New counseling programs are not required, and an entity may use existing counseling programs or referrals to provide these services.

Related blood donor records means any record, list, or compilation established in connection with a request for address information which indicates, directly or indirectly, the identity of any individual with respect to whom a request for address information has been made pursuant to the rules in this part.

(c) *Use of social security number for identification.* A State or an authorized person in the State may require a blood donor to furnish his or her social security number when donating blood. The number may then be used by an authorized person to identify and locate a donor whose blood donation indicates that he or she is or may be infected with the human immunodeficiency virus.

(d) *Request for address of blood donor.* An authorized person who has been unable to locate a blood donor at the address he or she may have given at the time of the blood donation may request assistance from the State agency which has arranged with us to participate in the Blood Donor Locator Service. The request to the Blood Donor Locator Service must—

(1) Be in writing;

(2) Be from a participating State agency either on its own behalf as an authorized person or on behalf of another authorized person;

(3) Indicate that the authorized person meets the confidentiality safeguards of paragraph (g) of this section; and

(4) Include the donor's name and social security number, the addresses at which the authorized person attempted without success to contact the donor, the date of the blood donation if available, a statement that the donor has tested positive for the human immunodeficiency virus according to the latest

Food and Drug Administration standards or that the history of the subsequent use of the donated blood or blood products indicates that the donor has or may have the human immunodeficiency virus, and the name and address of the requesting blood donation facility.

(e) *SSA response to request for address.* After receiving a request that meets the requirements of paragraph (d) of this section, we will search our records for the donor's latest personal mailing address. If we do not find a current address, we will request that the Internal Revenue Service search its tax records and furnish us any personal mailing address information from its files, as required under section 6103(m)(6) of the Internal Revenue Code. After completing these searches, we will provide to the requesting State agency either the latest mailing address available for the donor or a response stating that we do not have this information. We will then destroy the records or delete all identifying donor information related to the request and maintain only the information that we will need to monitor the compliance of authorized persons with the confidentiality safeguards contained in paragraph (g) of this section.

(f) *SSA refusal to furnish address.* If we determine that an authorized person has not met the requirements of paragraphs (d) and (g) of this section, we will not furnish address information to the State agency. In that case, we will notify the State agency of our determination, explain the reasons for our determination, and explain that the State agency may request administrative review of our determination. The Commissioner of Social Security or a delegate of the Commissioner will conduct this review. The review will be based on the information of record and there will not be an opportunity for an oral hearing. A request for administrative review, which may be submitted only by a State agency, must be in writing. The State agency must send its request for administrative review to the Commissioner of Social Security, 6401 Security Boulevard, Baltimore, MD 21235, within 60 days after receiving our notice refusing to give the donor's address. The request for review must include supporting information or evidence that the requirements of the rules in this part have been met. If we do not furnish address information because an authorized person failed to comply with the confidentiality safeguards of paragraph (g) of this section, the State agency will have an opportunity to submit evidence that the authorized person is now in compliance. If we then determine, based on our review of the request for administrative review and the supporting evidence, that the authorized person meets the requirements of the rules in this part, we will respond to the address request as provided in paragraph (e) of this section. If we determine on administrative review that the requirements have not been met, we will notify the State agency in writing of our decision. We will make our determination within 30 days after receiving the request for administrative review, unless we notify the State agency within this 30-day time period that we will need additional time. Our determination on the request for administrative review will give the findings of fact, the reasons for the decision, and what actions the State agency should take to ensure that it or the blood donation facility is in compliance with the rules in this part.

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

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

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

(3) Restrict access to these records to authorized employees and officials who

need them to perform their official duties related to notifying blood donors who are or may be infected with the human immunodeficiency virus that they may need medical care and treatment;

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

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

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

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

APPENDIX A TO PART 401—EMPLOYEE STANDARDS OF CONDUCT

(a) *General.* All SSA employees are required to be aware of their responsibilities under the Privacy Act of 1974, 5 U.S.C. 552a. Regulations implementing the Privacy Act are set forth in this part. Instruction on the requirements of the Act and regulation shall be provided to all new employees of SSA. In addition, supervisors shall be responsible for assuring that employees who are working with systems of records or who undertake new duties which require the use of systems of records are informed of their responsibilities. Supervisors shall also be responsible for assuring that all employees who work with such systems of records are periodically reminded of the requirements of the Privacy Act and are advised of any new provisions or interpretations of the Act.

(b) *Penalties.* (1) All employees must guard against improper disclosure of records which are governed by the Privacy Act. Because of the serious consequences of improper invasions of personal privacy, employees may be subject to disciplinary action and criminal prosecution for knowing and willful violations of the Privacy Act and regulation. In addition, employees may also be subject to disciplinary action for unknowing or unwillful violations, where the employee had notice of the provisions of the Privacy Act and regulations and failed to inform himself or herself sufficiently or to conduct himself or herself in accordance with the requirements to avoid violations.

(2) SSA may be subjected to civil liability for the following actions undertaken by its employees:

(a) Making a determination under the Privacy Act and §§401.65 and 401.70 not to amend an individual's record in accordance with his or her request, or failing to make such review in conformity with those provisions;

(b) Refusing to comply with an individual's request for notification of or access to a record pertaining to him or her;

(c) Failing to maintain any record pertaining to any individual with such accuracy, relevance, timeliness, and completeness as is necessary to assure fairness in any determination relating to the qualifications, character, rights, or opportunities of, or benefits to the individual that may be made on the basis of such a record, and consequently makes a determination which is adverse to the individual; or

(d) Failing to comply with any other provision of the Act or any rule promulgated thereunder, in such a way as to have an adverse effect on an individual.

(3) An employee may be personally subject to criminal liability as set forth below and in 5 U.S.C. 552a (i):

(a) *Willful disclosure.* Any officer or employee of SSA, who by virtue of his employment or official position, has possession of, or access to, agency records which contain individually identifiable information the disclosure of which is prohibited by the Privacy Act or by rules or regulations established thereunder, and who, knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and may be fined not more than $5,000.

(b) *Notice requirements.* Any officer or employee of SSA who willfully maintains a system of records without meeting the notice requirements [of the Privacy Act] shall be

guilty of a misdemeanor and may be fined not more than $5,000.

(c) *Rules governing employees not working with systems of records.* Employees whose duties do not involve working with systems of records will not generally disclose to any one, without specific authorization from their supervisors, records pertaining to employees or other individuals which by reason of their official duties are available to them. Notwithstanding the above, the following records concerning Federal employees are a matter of public record and no further authorization is necessary for disclosure:

(1) Name and title of individual.

(2) Grade classification or equivalent and annual rate of salary.

(3) Position description.

(4) Location of duty station, including room number and telephone number.

In addition, employees shall disclose records which are listed in SSA's Freedom of Information Regulation as being available to the public. Requests for other records will be referred to the responsible SSA Freedom of Information Officer. This does not preclude employees from discussing matters which are known to them personally, and without resort to a record, to official investigators of Federal agencies for official purposes such as suitability checks, Equal Employment Opportunity investigations, adverse action proceedings, grievance proceedings, etc.

(d) *Rules governing employees whose duties require use or reference to systems of records.* Employees whose official duties require that they refer to, maintain, service, or otherwise deal with systems of records (hereinafter referred to as ''Systems Employees'') are governed by the general provisions. In addition, extra precautions are required and systems employees are held to higher standards of conduct.

(1) Systems Employees shall:

(a) Be informed with respect to their responsibilities under the Privacy Act;

(b) Be alert to possible misuses of the system and report to their supervisors any potential or actual use of the system which they believe is not in compliance with the Privacy Act and regulation;

(c) Disclose records within SSA only to an employee who has a legitimate need to know the record in the course of his or her official duties;

(d) Maintain records as accurately as practicable.

(e) Consult with a supervisor prior to taking any action where they are in doubt whether such action is in conformance with the Act and regulation.

(2) Systems employees shall not:

(a) Disclose in any form records from a system of records except (1) with the consent or at the request of the subject individual; or (2) where its disclosure is permitted under §401.110.

(b) Permit unauthorized individuals to be present in controlled areas. Any unauthorized individuals observed in controlled areas shall be reported to a supervisor or to the guard force.

(c) Knowingly or willfully take action which might subject SSA to civil liability.

(d) Make any arrangements for the design, development, or operation of any system of records without making reasonable effort to provide that the system can be maintained in accordance with the Act and regulation.

(e) *Contracting officers.* In addition to any applicable provisions set forth above, those employees whose official duties involve entering into contracts on behalf of SSA shall also be governed by the following provisions:

(1) *Contracts for design, or development of systems and equipment.* The contracting officer shall not enter into any contract for the design or development of a system of records, or for equipment to store, service or maintain a system of records unless the contracting officer has made reasonable effort to ensure that the product to be purchased is capable of being used without violation of the Privacy Act or the regulations in this part. He shall give special attention to provision of physical safeguards.

(2) *Contracts for the operation of systems of records.* The Contracting Officer, in conjunction with other officials whom he feels appropriate, shall review all proposed contracts providing for the operation of systems of records prior to execution of the contracts to determine whether operation of the system of records is for the purpose of accomplishing a Department function. If it is determined that the operation of the system is to accomplish an SSA function, the contracting officer shall be responsible for including in the contract appropriate provisions to apply the provisions of the Privacy Act and regulation to the system, including prohibitions against improper release by the contractor, his employees, agents, or subcontractors.

(3) *Other service contracts.* Contracting officers entering into general service contracts shall be responsible for determining the appropriateness of including provisions in the contract to prevent potential misuse (inadvertent or otherwise) by employees, agents, or subcontractors of the contractor.

(f) *Rules governing SSA officials responsible for managing systems of records.* In addition to the requirements for Systems Employees, SSA officials responsible for managing systems of records as described in §401.40(c) (system managers) shall:

(1) Respond to all requests for notification of or access, disclosure, or amendment of records in a timely fashion in accordance with the Privacy Act and regulation;

(2) Make any amendment of records accurately and in a timely fashion;

(3) Inform all persons whom the accounting records show have received copies of the

record prior to the amendments of the correction; and

(4) Associate any statement of disagreement with the disputed record, and

(a) Transmit a copy of the statement to all persons whom the accounting records show have received a copy of the disputed record, and

(b) Transmit that statement with any future disclosure.

PART 402—AVAILABILITY OF INFORMATION AND RECORDS TO THE PUBLIC

Sec.

402.5 Scope and purpose.
402.10 Policy.
402.15 Relationship between the FOIA and the Privacy Act of 1974.
402.20 Requests not handled under the FOIA.
402.25 Referral of requests outside of SSA.
402.30 Definitions.
402.35 Publication.
402.40 Publications for sale.
402.45 Availability of records.
402.50 Availability of administrative staff manuals.
402.55 Materials available at district offices and branch offices.
402.60 Materials in field offices of the Office of Hearings and Appeals.
402.65 Health care information.
402.70 Reasons for withholding some records.
402.75 Exemption one for withholding records: National defense and foreign policy.
402.80 Exemption two for withholding records: Internal personnel rules and practices.
402.85 Exemption three for withholding records: Records exempted by other statutes.
402.90 Exemption four for withholding records: Trade secrets and confidential commercial or financial information.
402.95 Exemption five for withholding records: Internal memoranda.
402.100 Exemption six: Clearly unwarranted invasion of personal privacy.
402.105 Exemption seven for withholding records: Law enforcement.
402.110 Exemptions eight and nine for withholding records: Records on financial institutions; records on wells.
402.125 Who may release a record.
402.130 How to request a record.
402.135 Where to send a request.
402.140 How a request for a record is processed.
402.145 Responding to your request.
402.150 Release of records.
402.155 Fees to be charged—categories of requests.
402.160 Fees to be charged—general provisions.
402.165 Fee schedule.
402.170 Fees for providing records and related services for program purposes pursuant to section 1106 of the Social Security Act.
402.175 Fees for providing information and related services for non-program purposes.
402.180 Procedure on assessing and collecting fees for providing records.
402.185 Waiver or reduction of fees in the public interest.
402.190 Officials who may deny a request for records under FOIA.
402.195 How a request is denied.
402.200 How to appeal a decision denying all or part of a request.
402.205 U.S. District Court action.

AUTHORITY: Secs. 205, 702(a)(5), and 1106 of the Social Security Act; (42 U.S.C. 405, 902(a)(5), and 1306); 5 U.S.C. 552 and 552a; 8 U.S.C. 1360; 18 U.S.C. 1905; 26 U.S.C. 6103; 30 U.S.C. 923b; 31 U.S.C. 9701; E.O. 12600, 52 FR 23781, 3 CFR, 1987 Comp., p. 235.

SOURCE: 62 FR 4154, Jan. 29, 1997, unless otherwise noted.

§ 402.5 Scope and purpose.

The rules in this part relate to the availability to the public, pursuant to the Freedom of Information Act (FOIA) 5 U.S.C. 552, of records of the Social Security Administration (SSA). They describe how to make a FOIA request; who can release records and who can decide not to release; how much time it should take to make a determination regarding release; what fees may be charged; what records are available for public inspection; why some records are not released; and your right to appeal and then go to court if we refuse to release records. The rules in this part do not revoke, modify, or supersede the regulations of SSA relating to disclosure of information in part 401 of this chapter.

§ 402.10 Policy.

As a general policy, SSA follows a balanced approach in administering FOIA. We not only recognize the right of public access to information in the possession of SSA, but also protect the integrity of internal processes. In addition, we recognize the legitimate interests of organizations or persons who have submitted records to SSA or who would otherwise be affected by release

of records. For example, we have no discretion to release certain records, such as trade secrets and confidential commercial information, prohibited from release by law. This policy calls for the fullest responsible disclosure consistent with those requirements of administrative necessity and confidentiality which are recognized in the FOIA.

§ 402.15 Relationship between the FOIA and the Privacy Act of 1974.

(a) *Coverage.* The FOIA and the rules in this part apply to all SSA records. The Privacy Act, 5 U.S.C. 552a, applies to records that are about individuals, but only if the records are in a system of records. ''Individuals'' and ''system of records'' are defined in the Privacy Act and in 20 CFR 401.25.

(b) *Requesting your own records.* If you are an individual and request records, then to the extent you are requesting your own records in a system of records, we will handle your request under the Privacy Act. If there is any record that we need not release to you under those provisions, we will also consider your request under the FOIA and this rule, and we will release the record to you if the FOIA requires it.

(c) *Requesting another individual's record.* Whether or not you are an individual, if you request records that are about an individual (other than yourself) and that are in a system of records, we will handle your request under the FOIA and the rules in this part. However, if our disclosure in response to your request would be permitted by the Privacy Act's disclosure provision, (5 U.S.C. 552a(b)), for reasons other than the requirements of the FOIA, and if we decide to make the disclosure, then we will not handle your request under the FOIA and the rules in this part. For example, when we make routine use disclosures pursuant to requests, we do not handle them under the FOIA and the rules in this part. (''Routine use'' is defined in the Privacy Act and in 20 CFR 401.25.) If we handle your request under the FOIA and the rules in this part and the FOIA does not require releasing the record to you, then the Privacy Act may prohibit the release and remove our discretion to release.

§ 402.20 Requests not handled under the FOIA.

(a) We will not handle your request under the FOIA and the regulations in this part to the extent it asks for records that are currently available, either from SSA or from another part of the Federal Government, under a separate statute that provides specific activity for charging fees for those records. For example, we will not handle your request under the FOIA and the regulations in this part to the extent it asks for detailed earnings statements under the Social Security program.

(b) We will not handle your request under the FOIA and the regulations in this part if you are seeking a record that is distributed by SSA as part of its regular program activity, for example, public information leaflets distributed by SSA.

§ 402.25 Referral of requests outside of SSA.

If you request records that were created by, or provided to us by, another Federal agency, and if that agency asserts control over the records, we may refer the records and your request to that agency. We may likewise refer requests for classified records to the agency that classified them. In these cases, the other agency will process and respond to your request, to the extent it concerns those records, under that agency's regulation, and you need not make a separate request to that agency. We will notify you when we refer your request to another agency.

§ 402.30 Definitions.

As used in this part,

Agency means any executive department, military department, government corporation, government controlled corporation, or other establishment in the executive branch of the Federal Government, or any independent regulatory agency. A private organization is not an agency even if it is performing work under contract with the Government or is receiving Federal financial assistance. Grantee and contractor records are not subject to the FOIA unless they are in the possession or under the control of SSA or its agents. Solely for the purpose of

disclosure under the FOIA, we consider records of individual beneficiaries located in the State Disability Determination Services (DDS) to be agency records.

Commercial use means, when referring to a request, that the request is from or on behalf of one who seeks information for a use or purpose that furthers the commercial, trade, or profit interests of the requester or of a person on whose behalf the request is made. Whether a request is for a commercial use depends on the purpose of the request and the use to which the records will be put. The identity of the requester (individual, non-profit corporation, for-profit corporation) and the nature of the records, while in some cases indicative of that purpose or use, are not necessarily determinative. When a request is from a representative of the news media, a purpose or use supporting the requester's news dissemination function is not a commercial use.

Duplication means the process of making a copy of a record and sending it to the requester, to the extent necessary to respond to the request. Such copies include paper copy, microfilm, audio-visual materials, and magnetic tapes, cards, and discs.

Educational institution means a preschool, elementary or secondary school, institution of undergraduate or graduate higher education, or institution of professional or vocational education, which operates a program of scholarly research.

Freedom of Information Act or *FOIA* means 5 U.S.C. 552.

Freedom of Information Officer means an SSA official who has been delegated the authority to authorize disclosure of or withhold records and assess, waive, or reduce fees in response to FOIA requests.

Non-commercial scientific institution means an institution that is not operated substantially for purposes of furthering its own or someone else's business, trade, or profit interests, and that is operated for purposes of conducting scientific research whose results are not intended to promote any particular product or industry.

Records means any information maintained by an agency, regardless of forms or characteristics, that is made or received in connection with official business. This includes handwritten, typed, or printed documents (such as memoranda, books, brochures, studies, writings, drafts, letters, transcripts, and minutes) and material in other forms, such as punchcards; magnetic tapes; cards; computer discs or other electronic formats; paper tapes; audio or video recordings; maps; photographs; slides; microfilm; and motion pictures. It does not include objects or articles such as exhibits, models, equipment, and duplication machines, audiovisual processing materials, or computer software. It does not include personal records of an employee, or books, magazines, pamphlets, or other reference material in formally organized and officially designated SSA libraries, where such materials are available under the rules of the particular library.

Representative of the news media means a person actively gathering information for an entity organized and operated to publish or broadcast news to the public. News media entities include television and radio broadcasters, publishers of periodicals who distribute their products to the general public or who make their products available for purchase or subscription by the general public, and entities that may disseminate news through other media (e.g., electronic dissemination of text). We will treat freelance journalists as representatives of a news media entity if they can show a likelihood of publication through such an entity. A publication contract is such a basis, and the requester's past publication record may show such a basis.

Request means asking for records, whether or not you refer specifically to the FOIA. Requests from Federal agencies and court orders for documents are not included within this definition. Subpoenas are requests only to the extent provided by 45 CFR 2.

Review means, when used in connection with processing records for a commercial use request, examining the records to determine what portions, if any, may be withheld, and any other processing that is necessary to prepare the records for release. It includes only the examining and processing that are done the first time we analyze whether

a specific exemption applies to a particular record or portion of a record. It does not include examination done in the appeal stage with respect to an exemption that was applied at the initial request stage. However, if we initially withhold a record under one exemption, and on appeal we determine that that exemption does not apply, then examining the record in the appeal stage for the purpose of determining whether a different exemption applies is included in *review*. It does not include the process of researching or resolving general legal or policy issues regarding exemptions.

Search means looking for records or portions of records responsive to a request. It includes reading and interpreting a request, and also page-by-page and line-by-line examination to identify responsive portions of a document. However, it does not include line-by-line examination where merely duplicating the entire page would be a less expensive and quicker way to comply with the request.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35132, June 29, 1998]

§ 402.35 Publication.

(a) *Methods of publication*. Materials we are required to publish pursuant to the provisions of 5 U.S.C. 552 (a)(1) and (a)(2), we publish in one of the following ways:

(1) By publication in the FEDERAL REGISTER of Social Security Administration regulations, and by their subsequent inclusion in the Code of Federal Regulations;

(2) By publication in the FEDERAL REGISTER of appropriate general notices;

(3) By other forms of publication, when incorporated by reference in the FEDERAL REGISTER with the approval of the Director of the FEDERAL REGISTER; and

(4) By publication in the ''Social Security Rulings'' of indexes of precedential social security orders and opinions issued in the adjudication of claims, statements of policy and interpretations which have been adopted but have not been published in the FEDERAL REGISTER. The ''Social Security Rulings'' may be purchased through the Government Printing Office (See § 402.40).

(b) *Publication of rulings*. Although not required pursuant to 5 U.S.C. 552 (a)(1) and (a)(2), we publish the following rulings in the FEDERAL REGISTER as well as by other forms of publication:

(1) We publish Social Security Rulings in the FEDERAL REGISTER under the authority of the Commissioner of Social Security. They are binding on all components of the Social Security Administration. These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted.

(2) We publish Social Security Acquiescence Rulings in the FEDERAL REGISTER under the authority of the Commissioner of Social Security. They are binding on all components of the Social Security Administration, except with respect to claims subject to the relitigation procedures established in 20 CFR 404.984, 410.610, and 416.1484. For a description of Social Security Acquiescence Rulings, see 20 CFR 404.984(b), 410.610c(b), and 416.1484(b) of this title.

(c) *Availability for inspection*. To the extent practicable and to further assist the public, we make available for inspection at the address specified in § 402.135 those materials which are published in the FEDERAL REGISTER pursuant to 5 U.S.C. 552(a)(1).

(d) *Availability by Telecommunications*. To the extent practicable, we will make available by means of computer telecommunications the indices and other records that are available for inspection.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35132, June 29, 1998; 65 FR 16813, Mar. 30, 2000]

§ 402.40 Publications for sale.

The following publications containing information pertaining to the program, organization, functions, and procedures of the Social Security Administration may be purchased from the Superintendent of Documents, Government Printing Office, Washington, DC 20402:

(a) Title 20, parts 400–499 of the Code of Federal Regulations.

(b) FEDERAL REGISTER issues.

(c) Compilation of the Social Security Laws.

(d) Social Security Rulings.

(e) Social Security Handbook. The information in the Handbook is not of precedent or interpretative force.

(f) Social Security Bulletin.

(g) Social Security Acquiescence Rulings.

(h) SSA Publications on CD-ROM.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35132, June 29, 1998]

§ 402.45 Availability of records.

(a) *What records are available.* 5 U.S.C. 552, also known as the FOIA, permits any person to see, and get a copy of, any Federal agency's records unless the material is exempt from mandatory disclosure as described in § 402.70 of this part.

(b) *FOIA.* Under the FOIA, we are also required to make available to the public the instructional manuals issued to our employees, general statements of policy, and other materials which are used in processing claims and which are not published in the FEDERAL REGISTER, and an index of these manuals and materials.

(c) *Record citation as precedent.* We will not use or cite any record described in paragraph (b) of this section as a precedent for an action against a person unless we have indexed the record and published it or made it available, or unless the person has timely notice of the record.

(d) *Electronic Reading Room.* We will prepare an index of records which have become or are likely to become the subject of subsequent requests. The index, and, to the extent practicable, the records will be made available on the Internet or by other computer telecommunications means.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35132, June 29, 1998]

§ 402.50 Availability of administrative staff manuals.

All administrative staff manuals of the Social Security Administration and instructions to staff personnel which contain policies, procedures, or interpretations that affect the public are available for inspection and copying. A complete listing of such materials is published in the Index of Administrative Staff Manuals and Instructions. These manuals are generally not printed in a sufficient quantity to permit sale or other general distribution to the public. Selected material is maintained at district offices and field offices and may be inspected there. See §§ 402.55 and 402.60 for a listing of this material.

§ 402.55 Materials available at district offices and branch offices.

(a) *Materials available for inspection.* The following are available or will be made available for inspection at the district offices and branch offices:

(1) Compilation of the Social Security Laws.

(2) Social Security Administration regulations under the retirement, survivors, disability, and supplemental security income programs, i.e., 20 CFR parts 401, 402, 404, 416, and 422; and the Social Security Administration's regulations under part B of title IV (Black Lung Benefits) of the Federal Coal Mine Health and Safety Act of 1969, 20 CFR part 410.

(3) Social Security Rulings.

(4) Social Security Handbook.

(5) Social Security Acquiescence Rulings.

(b) *Materials available for inspection and copying.* The following materials are available or will be made available for inspection and copying at the district offices and branch offices (fees may be applicable per §§ 402.155 through 402.185):

(1) SSA Program Operations Manual System.

(2) SSA Organization Manual.

(3) Handbook for State Social Security Administrators.

(4) Indexes to the materials listed in paragraph (a) of this section and in this paragraph (b) and an index to the Hearings, Appeals and Litigation Law (HALLEX) manual.

(5) Index of Administrative Staff Manuals and Instructions.

§ 402.60 Materials in field offices of the Office of Hearings and Appeals.

(a) *Materials available for inspection.* The following materials are available for inspection in the field offices of the Office of Hearings and Appeals:

(1) Regulations of the Social Security Administration (see § 402.55(a)(2)).

(2) Title 5, United States Code.

(3) Compilation of the Social Security Laws.

(4) Social Security Rulings.

(5) Social Security Handbook.

(6) Social Security Acquiescence Rulings.

(b) The Hearings, Appeals and Litigation Law (HALLEX) manual is available for inspection and copying in the field offices of the Office of Hearings and Appeals (fees may be applicable per §§ 402.155 through 402.185).

§ 402.65 Health care information.

We have some information about health care programs under titles XVIII and XIX (Medicare and Medicaid) of the Social Security Act. We follow the rules in 42 CFR part 401 in determining whether to provide any portion of it to a requester.

§ 402.70 Reasons for withholding some records.

Section 552(b) of the Freedom of Information Act contains nine exemptions to the mandatory disclosure of records. We describe these exemptions in §§ 402.75 through 402.110 of this part and explain how we apply them to disclosure determinations. (In some cases more than one exemption may apply to the same document.) Information obtained by the agency from any individual or organization, furnished in reliance on a provision for confidentiality authorized by applicable statute or regulation, will not be disclosed, to the extent it can be withheld under one of these exemptions. This section does not itself authorize the giving of any pledge of confidentiality by any officer or employee of the agency.

§ 402.75 Exemption one for withholding records: National defense and foreign policy.

We are not required to release records that, as provided by FOIA, are ''(a) specifically authorized under criteria established by an Executive Order to be kept secret in the interest of national defense or foreign policy and (b) are in fact properly classified pursuant to such Executive Order.'' Executive Order No. 12958 (1995) (3 CFR, 1987 Comp., p. 235) provides for such classification. When the release of certain records may adversely affect U.S. relations with foreign countries, we usually consult with officials of those countries or officials of the Department of State. Also, we may on occasion have in our possession records classified by some other agency. We may refer your request for such records to the agency that classified them and notify you that we have done so.

§ 402.80 Exemption two for withholding records: Internal personnel rules and practices.

We are not required to release records that are ''related solely to the internal personnel rules and practices of an agency.'' Under this exemption, we may withhold routine internal agency practices and procedures. For example, we may withhold guard schedules and rules governing parking facilities or lunch periods. Also under this exemption, we may withhold internal records whose release would help some persons circumvent the law or agency regulations. For example, we ordinarily do not disclose manuals that instruct our investigators or auditors how to investigate possible violations of law, to the extent that this release would help some persons circumvent the law.

§ 402.85 Exemption three for withholding records: Records exempted by other statutes.

We are not required to release records if another statute specifically allows or requires us to withhold them. We may use another statute to justify withholding only if it absolutely prohibits disclosure or if it sets forth criteria to guide our decision on releasing or identifies particular types of material to be withheld. We often use this exemption to withhold information regarding a worker's earnings which is tax return information under section 6103 of the Internal Revenue Code.

§ 402.90 Exemption four for withholding records: Trade secrets and confidential commercial or financial information.

We will withhold trade secrets and commercial or financial information

that is obtained from a person and is privileged or confidential.

(a) *Trade secrets.* A trade secret is a secret, commercially valuable plan, formula, process, or device that is used for the making, preparing, compounding, or processing of trade commodities and that can be said to be the end product of either innovation or substantial effort. There must be a direct relationship between the trade secret and the productive process.

(b) *Commercial or financial information.* We will not disclose records whose information is ''commercial or financial,'' is obtained from a person, and is ''privileged or confidential.''

(1) Information is ''commercial or financial'' if it relates to businesses, commerce, trade, employment, profits, or finances (including personal finances). We interpret this category broadly.

(2) Information is ''obtained from a person'' if SSA or another agency has obtained it from someone outside the Federal Government or from someone within the Government who has a commercial or financial interest in the information. ''Person'' includes an individual, partnership, corporation, association, State or foreign government, or other organization. Information is not ''obtained from a person'' if it is generated by SSA or another Federal agency. However, information is ''obtained from a person'' if it is provided by someone, including but not limited to an agency employee, who retains a commercial or financial interest in the information.

(3) Information is ''privileged'' if it would ordinarily be protected from disclosure in civil discovery by a recognized evidentiary privilege, such as the attorney-client privilege or the work product privilege. Information may be privileged for this purpose under a privilege belonging to a person outside the government, unless the providing of the information to the government rendered the information no longer protectable in civil discovery.

(4) Information is ''confidential'' if it meets one of the following tests:

(i) Disclosure may impair the government's ability to obtain necessary information in the future;

(ii) Disclosure would substantially harm the competitive position of the person who submitted the information;

(iii) Disclosure would impair other government interests, such as program effectiveness and compliance; or

(iv) Disclosure would impair other private interests, such as an interest in controlling availability of intrinsically valuable records, which are sold in the market by their owner.

(c) *Analysis under tests in this section.* The following questions may be relevant in analyzing whether a record meets one or more of the above tests:

(1) Is the information of a type customarily held in strict confidence and not disclosed to the public by the person to whom it belongs?

(2) What is the general custom or usage with respect to such information in the relevant occupation or business?

(3) How many, and what types of, individuals have access to the information?

(4) What kind and degree of financial injury can be expected if the information is disclosed?

(d) *Designation of certain confidential information.* A person who submits records to the government may designate part or all of the information in such records as exempt from disclosure under Exemption 4 of the FOIA. The person may make this designation either at the time the records are submitted to the government or within a reasonable time thereafter. The designation must be in writing. Where a legend is required by a request for proposals or request for quotations, pursuant to 48 CFR 352.215–12, then that legend is necessary for this purpose. Any such designation will expire ten years after the records were submitted to the government.

(e) *Predisclosure notification.* The procedures in this paragraph apply to records on which the submitter has designated information as provided in paragraph (d) of this section. They also apply to records that were submitted to the government where we have substantial reason to believe that information in the records could reasonably be considered exempt under Exemption 4. Certain exceptions to these procedures are stated in paragraph (f) of this section.

(1) When we receive a request for such records, and we determine that we may be required to disclose them, we will make reasonable efforts to notify the submitter about these facts. The notice will include a copy of the request, and it will inform the submitter about the procedures and time limits for submission and consideration of objections to disclosure. If we must notify a large number of submitters, we may do this by posting or publishing a notice in a place where the submitters are reasonably likely to become aware of it.

(2) The submitter has five working days from receipt of the notice to object to disclosure of any part of the records and to state all bases for its objections.

(3) We will give consideration to all bases that have been timely stated by the submitter. If we decide to disclose the records, we will notify the submitter in writing. This notice will briefly explain why we did not sustain its objections. We will include with the notice a copy of the records about which the submitter objected, as we propose to disclose them. The notice will state that we intend to disclose the records five working days after the submitter receives the notice unless we are ordered by a United States District Court not to release them.

(4) When a requester files suit under the FOIA to obtain records covered by this paragraph, we will promptly notify the submitter.

(5) Whenever we send a notice to a submitter under paragraph (e)(1) of this section, we will notify the requester that we are giving the submitter a notice and an opportunity to object. Whenever we send a notice to a submitter under paragraph (e)(3) of this section, we will notify the requester of this fact.

(f) *Exceptions to predisclosure notification.* The notice requirements in paragraph (e) of this section do not apply in the following situations:

(1) We decided not to disclose the records;

(2) The information has previously been published or made generally available;

(3) Disclosure is required by a regulation, issued after notice and opportunity for public comment, that specifies narrow categories of records that are to be disclosed under the FOIA, but in this case a submitter may still designate records as described in paragraph (d) of this section, and in exceptional cases, we may, at our discretion, follow the notice procedures in paragraph (e) of this section; or

(4) The designation appears to be obviously frivolous, but in this case we will still give the submitter the written notice required by paragraph (e)(3) of this section (although this notice need not explain our decision or include a copy of the records), and we will notify the requester as described in paragraph (e)(5) of this section.

§ 402.95 Exemption five for withholding records: Internal memoranda.

This exemption covers internal government communications and notes that fall within a generally recognized evidentiary privilege. Internal government communications include an agency's communications with an outside consultant or other outside person, with a court, or with Congress, when those communications are for a purpose similar to the purpose of privileged intra-agency communications. Some of the most-commonly applicable privileges are described in the following paragraphs:

(a) *Deliberative process privilege.* This privilege protects predecisional deliberative communications. A communication is protected under this privilege if it was made before a final decision was reached on some question of policy and if it expressed recommendations or opinions on that question. The purpose of the privilege is to prevent injury to the quality of the agency decisionmaking process by encouraging open and frank internal policy discussions, by avoiding premature disclosure of policies not yet adopted, and by avoiding the public confusion that might result from disclosing reasons that were not in fact the ultimate grounds for an agency's decision. Purely factual material in a deliberative document is within this privilege only if it is inextricably intertwined with the deliberative portions so that it cannot reasonably be segregated, if it

would reveal the nature of the deliberative portions, or if its disclosure would in some other way make possible an intrusion into the decisionmaking process. We will release purely factual material in a deliberative document unless that material is otherwise exempt. The privilege continues to protect predecisional documents even after a decision is made.

(b) *Attorney work product privilege.* This privilege protects documents prepared by or for an agency, or by or for its representative (typically, our attorneys) in anticipation of litigation or for trial. It includes documents prepared for purposes of administrative adjudications as well as court litigation. It includes documents prepared by program offices as well as by attorneys. It includes factual material in such documents as well as material revealing opinions and tactics. Finally, the privilege continues to protect the documents even after the litigation is closed.

(c) *Attorney-client communication privilege.* This privilege protects confidential communications between a lawyer and an employee or agent of the Government where there is an attorney-client relationship between them (typically, where the lawyer is acting as attorney for the agency and the employee is communicating on behalf of the agency) and where the employee has communicated information to the attorney in confidence in order to obtain legal advice or assistance.

§ 402.100 Exemption six: Clearly unwarranted invasion of personal privacy.

(a) *Documents affected.* We may withhold records about individuals if disclosure would constitute a clearly unwarranted invasion of their personal privacy.

(b) *Balancing test.* In deciding whether to release records to you that contain personal or private information about someone else, we weigh the foreseeable harm of invading a person's privacy against the public interest in disclosure. In determining whether disclosure would be in the public interest, we will consider whether disclosure of the requested information would shed light on how a Government agency performs its statutory duties. However, in our evaluation of requests for records we attempt to guard against the release of information that might involve a violation of personal privacy because of a requester being able to ''read between the lines'' or piece together items that would constitute information that normally would be exempt from mandatory disclosure under Exemption Six.

(c) *Examples.* Some of the information that we frequently withhold under Exemption Six is: Home addresses, ages, and minority group status of our employees or former employees; social security numbers; medical information about individuals who have filed a claim for disability benefits; names and addresses of individual beneficiaries of our programs, or benefits such individuals receive; earnings records, claim files, and other personal information SSA maintains.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35132, June 29, 1998]

§ 402.105 Exemption seven for withholding records: Law enforcement.

We are not required to disclose information or records that the government has compiled for law enforcement purposes. The records may apply to actual or potential violations of either criminal or civil laws or regulations. We can withhold these records only to the extent that releasing them would cause harm in at least one of the following situations:

(a) *Enforcement proceedings.* We may withhold information whose release could reasonably be expected to interfere with prospective or ongoing law enforcement proceedings. Investigations of fraud and mismanagement, employee misconduct, and civil rights violations may fall into this category. In certain cases—such as when a fraud investigation is likely—we may refuse to confirm or deny the existence of records that relate to the violations in order not to disclose that an investigation is in progress, or may be conducted.

(b) *Fair trial or impartial adjudication.* We may withhold records whose release would deprive a person of a fair trial or an impartial adjudication because of prejudicial publicity.

(c) *Personal privacy*. We are careful not to disclose information that could reasonably be expected to constitute an unwarranted invasion of personal privacy. When a name surfaces in an investigation, that person is likely to be vulnerable to innuendo, rumor, harassment, and retaliation.

(d) *Confidential sources and information*. We may withhold records whose release could reasonably be expected to disclose the identity of a confidential source of information. A confidential source may be an individual; a State, local, or foreign government agency; or any private organization. The exemption applies whether the source provides information under an express promise of confidentiality or under circumstances from which such an assurance could be reasonably inferred. Also, where the record, or information in it, has been compiled by a law enforcement authority conducting a criminal investigation, or by an agency conducting a lawful national security investigation, the exemption also protects all information supplied by a confidential source. Also protected from mandatory disclosure is any information which, if disclosed, could reasonably be expected to jeopardize the system of confidentiality that assures a flow of information from sources to investigatory agencies.

(e) *Techniques and procedures*. We may withhold records reflecting special techniques or procedures of investigation or prosecution, not otherwise generally known to the public. In some cases, it is not possible to describe even in general terms those techniques without disclosing the very material to be withheld. We may also withhold records whose release would disclose guidelines for law enforcement investigations or prosecutions if this disclosure could reasonably be expected to create a risk that someone could circumvent requirements of law or of regulation.

(f) *Life and physical safety*. We may withhold records whose disclosure could reasonably be expected to endanger the life or physical safety of any individual. This protection extends to threats and harassment as well as to physical violence.

[62 FR 4154, Jan. 29, 1997. Redesignated at 63 FR 35132, June 29, 1998]

§ 402.110 Exemptions eight and nine for withholding records: Records on financial institutions; records on wells.

Exemption eight permits us to withhold records about regulation or supervision of financial institutions. Exemption nine permits the withholding of geological and geophysical information and data, including maps, concerning wells.

§ 402.125 Who may release a record.

Except as otherwise provided by regulation, only the Director, Office of Disclosure Policy, SSA, or her or his designee may determine whether to release any record in SSA's control and possession. This official is SSA's Freedom of Information Officer. Sections 402.40, 402.55, and 402.60 list some of the materials which we have determined may be released.

§ 402.130 How to request a record.

You may request a record in person or by mail or by electronic telecommunications. To the extent practicable, and in the future, we will attempt to provide access for requests by telephone, fax, Internet, and e-mail. Any request should reasonably describe the record you want. If you have detailed information which would assist us in identifying that record, please submit it with your request. We may charge fees for some requests (§§ 402.145–402.175 explain our fees). You should identify the request as a Freedom of Information Act request and mark the outside of any envelope used to submit your request as a ''Freedom of Information Request.'' The staff at any Social Security office can help you prepare this request.

[63 FR 35132, June 29, 1998]

§ 402.135 Where to send a request.

You may send your request for a record to: The Director, Office of Disclosure Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235.

§ 402.140 How a request for a record is processed.

(a) In general, we will make a determination as to whether a requested record will be provided within 20 days (excepting Saturdays, Sundays, and legal public holidays) after receipt of a request by the appropriate official (see § 402.135). This 20-day period may be extended in unusual circumstances by written notice to you, explaining why we need additional time, and the extension may be for up to 10 additional working days when one or more of the following situations exist:

(1) The office processing the request needs to locate and then obtain the record from another facility;

(2) We need to locate, obtain, and appropriately examine a large number of records which are requested in a single request; or

(3) The office processing the request needs to consult with another agency which has a substantial interest in the subject matter of the request. This consultation shall be conducted with all practicable speed.

(b) If we cannot process your request within 10 additional days, we will notify you and provide you an opportunity to limit the scope of the request so that it may be processed within the additional 10 days, or we will provide you with an opportunity to arrange with us an alternative time frame for processing the request, or for processing a modified request.

(c) *Multi-tracking procedures.* We will establish four tracks for handling requests and the track to which a request is assigned will depend on the nature of the request and the estimated processing time:

(1) Track 1—Requests that can be answered with readily available records or information. These are the fastest to process.

(2) Track 2—Requests where we need records or information from other offices throughout the Agency but we do not expect that the decision on disclosure will be as time consuming as for requests in Track 3.

(3) Track 3—Requests which require a decision or input from another office or agency and a considerable amount of time will be needed for that, or the request is complicated or involves a large number of records. Usually, these cases will take the longest to process.

(4) Track 4—Requests that will be expedited.

(d) We will provide for expedited access for requesters who show a ''compelling need'' for a speedy response. The EFOIA describes compelling need as when the failure to obtain the records on an expedited basis could reasonably be expected to pose ''an imminent threat to the life or physical safety of an individual,'' or when the request is from a person primarily engaged in disseminating information (such as a member of the news media), and there is an ''urgency to inform the public concerning actual or alleged Federal Government activity.'' We also will expedite processing of a request if the requester explains in detail to our satisfaction that a prompt response is needed because the requester may be denied a legal right, benefit, or remedy without the requested information, and that it cannot be obtained elsewhere in a reasonable amount of time. We will respond within 10 days to a request for expedited processing and, if we decide to grant expedited processing, we will then notify you of our decision whether or not to disclose the records requested as soon as practicable.

[63 FR 35133, June 29, 1998]

§ 402.145 Responding to your request.

(a) *Retrieving records.* We are required to furnish copies of records only when they are in our possession or we can retrieve them from storage. We will make reasonable efforts to search for records manually or by automated means, including any information stored in an electronic form or format, except when such efforts would significantly interfere with the operation of our automated information system. If we have stored the records you want in the National Archives or another storage center, we will retrieve and review them for possible disclosure. However, the Federal Government destroys many old records, so sometimes it is impossible to fill requests. Various laws, regulations, and manuals give the time periods for keeping records before they may be destroyed. For example, there is information about retention of records in the Records Disposal Act of

1944, 44 U.S.C. 3301 through 3314; the Federal Property Management Regulations, 41 CFR 101–11.4; and the General Records Schedules of the National Archives and Records Administration.

(b) *Furnishing records.* We will furnish copies only of records that we have or can retrieve. We are not required to create new records or to perform research for you. We may decide to conserve Government resources and at the same time supply the records you need by consolidating information from various records rather than copying them all. For instance, we could extract sections from various similar records instead of providing repetitious information. We generally will furnish only one copy of a record. We will make reasonable efforts to provide the records in the form or format you request if the record is readily reproducible in that form or format.

(c) *Deletions.* When we publish or otherwise make available any record, we may delete information that is exempt from disclosure. For example, in an opinion or order, statement of policy, or other record which relates to a private party or parties, the name or names and other identifying details may be deleted. When technically feasible, we will indicate the extent of deletions on the portion of the record that is released or published at the place of the deletion unless including that indication would harm an interest protected by an exemption. If we deny a request, in whole or in part, we will make a reasonable effort to estimate the volume of any requested matter that is not disclosed, unless such an estimate would harm an interest protected by an exemption.

(d) *Creation of records.* We are not required to create new records merely to satisfy a request. However, we will search manually or by automated means to locate information that is responsive to the request. If extensive computer programming is needed to respond to a request, we may decline to commit such resources, or if we agree to do so, we may charge you for the reasonable cost of doing so. We do not mean that we will never help you get information that does not already exist in our records. However, diverting staff and equipment from our other responsibilities may not always be possible.

[63 FR 35133, June 29, 1998]

§ 402.150 Release of records.

(a) *Records previously released.* If we have released a record, or a part of a record, to others in the past, we will ordinarily release it to you also. However, we will not release it to you if a statute forbids this disclosure, and we will not necessarily release it to you if an exemption applies in your situation and it did not apply, or applied differently, in the previous situation(s) or if the previous release was unauthorized. See § 402.45(d) regarding records in electronic reading rooms.

(b) *Poor copy.* If we cannot make a legible copy of a record to be released, we do not attempt to reconstruct it. Instead, we furnish the best copy possible and note its poor quality in our reply.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35133, June 29, 1998]

§ 402.155 Fees to be charged—categories of requests.

Paragraphs (a) through (c) of this section state, for each category of request, the type of fees that we will generally charge. However, for each of these categories, the fees may be limited, waived, or reduced for the reasons given below or for other reasons.

(a) *Commercial use request.* If your request is for a commercial use, we will charge you the costs of search, review, and duplication.

(b) *Educational and scientific institutions and news media.* If you are an educational institution or a non-commercial scientific institution, operated primarily for scholarly or scientific research, or a representative of the news media, and your request is not for a commercial use, we will charge you only for the duplication of documents. Also, we will not charge you the copying costs for the first 100 pages of duplication.

(c) *Other requesters.* If your request is not the kind described by paragraph (a) or (b) of this section, then we will charge you only for the search and the duplication. Also, we will not charge you for the first two hours of search

time or for the copying costs of the first 100 pages of duplication.

§ 402.160 Fees to be charged—general provisions.

(a) We may charge search fees even if the records we find are exempt from disclosure, or even if we do not find any records at all.

(b) If we are not charging you for the first two hours of search time, under paragraph (c) of § 402.155, and those two hours are spent on a computer search, then the two free hours are the first two hours of the time needed to access the information in the computer.

(c) If we are not charging you for the first 100 pages of duplication, under paragraph (b) or (c) of § 402.155, then those 100 pages are the first 100 pages of photocopies of standard size pages, or the first 100 pages of computer printout.

(d) We will charge interest on unpaid bills beginning on the 31st day following the day the bill was sent.

[62 FR 4154, Jan. 29, 1997, as amended at 63 FR 35134, June 29, 1998]

§ 402.165 Fee schedule.

The following is our fee schedule for providing records and related services under the FOIA:

(a) *Manual searching for or reviewing of records.* When the search or review is performed by employees at grade GS–1 through GS–8, we will charge an hourly rate based on the salary of a GS–5, step 7, employee; when done by a GS–9 through GS–14, an hourly rate based on the salary of a GS–12, step 4, employee; and when done by a GS–15 or above, an hourly rate based on the salary of a GS–15, step 7, employee. In each case, we will compute the hourly rate by taking the current hourly rate for the specified grade and step, adding 16% of that rate to cover benefits, and rounding to the nearest whole dollar. As of January 5, 1997, these rates were $14, $28, and $50 respectively. These rates are adjusted as Federal salaries change. When a search involves employees at more than one of these levels, we will charge the rate appropriate for each.

(b) *Computer searching and printing.* We will charge the actual cost of operating the computer plus charges for the time spent by the operator, at the rates given in paragraph (a) of this section.

(c) *Photocopying standard size pages.* We will charge $0.10 per page. The Freedom of Information (FOI) Officer may charge lower fees for particular documents where—

(1) The document has already been printed in large numbers;

(2) The program office determines that using existing stock to answer this request, and any other anticipated FOI requests, will not interfere with program requirements; and

(3) The FOI Officer determines that the lower fee is adequate to recover the prorated share of the original printing costs.

(d) *Photocopying odd-size documents.* For photocopying documents such as punchcards or blueprints, or reproducing other records such as tapes, we will charge the actual costs of operating the machine, plus the actual cost of the materials used, plus charges for the time spent by the operator, at the rates given in paragraph (a) of this section.

(e) *Certifying that records are true copies.* This service is not required by the FOIA. If we agree to provide it, we will charge $10 per certification.

(f) *Sending records by express mail, certified mail, or other special methods.* This service is not required by the FOIA. If we agree to provide it, we will charge our actual costs.

(g) *Other special services.* For performing any other special service that you request and we agree to, we will charge the actual costs of operating any machinery, plus actual cost of any materials used, plus charges for the time of our employees, at the rates given in paragraph (a) of this section.

(h) *Billing exceeds cost of service.* Generally we will not charge you a fee when the cost of the service is less than the cost of sending you a bill. However, where an individual, organization, or governmental unit makes multiple separate requests, we will total the costs incurred and periodically bill the requester for the services rendered.

(i) *Fee for copies of printed materials.* When extra copies of printed material are available, the charge is generally 1

cent per page. If the material may be purchased from the Superintendent of Documents, the charge is that set by the Superintendent. The Superintendent's address is in § 402.40.

(j) *When not applicable.* This fee schedule does not apply to requests for records of Social Security number holders, wage earners, employers, and claimants when the requests are governed by section 1106 of the Social Security Act and by §§ Sections 402.170 and 402.175.

§ 402.170 Fees for providing records and related services for program purposes pursuant to section 1106 of the Social Security Act.

(a) *Program purposes described.* (1) We consider a request to be program related if the information must be disclosed under the Social Security Act. For example, section 205(c)(2)(A) of the Act (42 U.S.C. 405(c)(2)(A)) requires that we provide certain information upon request to a worker, her or his legal representative, her or his survivor, or the legal representative of the worker's estate. That information is the amounts of the worker's wages and self-employment income and the periods during which they were paid or derived, as shown by our records.

(2) We also consider a request to be program related if the requester indicates the needed information will be used for a purpose which is directly related to the administration of a program under the Social Security Act.

(i) The major criteria we consider in deciding whether a proposed use is so related are:

(A) Is the information needed to pursue some benefit under the Act?

(B) Is the information needed solely to verify the accuracy of information obtained in connection with a program administered under the Act?

(C) Is the information needed in connection with an activity which has been authorized under the Act?

(D) Is the information needed by an employer to carry out her or his taxpaying responsibilities under the Federal Insurance Contributions Act or section 218 of the Act?

(ii) We will consider on a case by case basis those requests which do not meet these criteria but are claimed to be program related.

(b) *When we charge.* If we determine the request for information is program related, we may or may not charge for the information. For example, as stated in paragraph (a) of this section, we generally will not charge you for information needed to assure the accuracy of our records on which your present or future Social Security benefits depend. In addition, we generally will not charge for furnishing information under section 205(c)(2)(A) of the Act. However, if we do charge for a program related request (for example, if more detailed information or special services are requested) we will use the fee schedule in § 402.165 if information is being disclosed under the FOIA and the fee schedule in 20 CFR 401.95 if access to the information is being granted under the Privacy Act. (Exception: If the request is for purposes of administering employee benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA), even if the request is covered by section 205(c)(2)(A) of the Act, we will charge under § 402.175.)

§ 402.175 Fees for providing information and related services for non-program purposes.

(a) *General.* Section 1106(c) of the Social Security Act permits the Commissioner to require requesters of information to pay the full cost of supplying the information where the information is requested to comply with the ERISA, or "*** for any other purpose not directly related to the administration of the program or programs under ***" the Social Security Act. This may be done notwithstanding the fee provisions of the FOIA and the Privacy Act or any other provision of law. As used in this section—

(1) Full cost includes the direct and indirect costs to SSA (including costs of duplication) of providing information and related services under section 1106(c) of the Act; and

(2) Full cost of an employee's time includes fringe benefits and overhead costs such as rent and utilities.

(b) *Non-program related requests.* We consider a request for information which does not meet or equal any of

the criteria in § 402.170 to be non-program related. (Whether a request for information about an individual is made by that individual or by someone else is not a factor.) In responding to these requests, or requests for ERISA purposes, we will charge the full cost of our services as described in paragraph (c) of this section.

(c) *Fee schedule.* Our fee schedule for non-program related requests is:

(1) *Manual searching for records.* Full cost of the employee's time.

(2) *Photocopying, or reproducing records such as magnetic tapes or punch cards.* Full cost of the operator's time plus the full cost of the machine time and the materials used.

(3) *Use of electronic data processing equipment to obtain records.* Our full cost for the service, including computer search time, computer runs and printouts, and the time of computer programmers and operators and other employees.

(4) *Certification or authentication of records.* Full cost of certification or authentication.

(5) *Forwarding materials to destination.* If you request special arrangements for forwarding the material, we will charge you the full cost of this service (e.g., you request express mail or a commercial delivery service). If no special forwarding arrangements are requested, we will charge you the full cost of the service, including the U.S. Postal Service cost.

(6) *Performing other special services.* If we agree to provide any special services you request, we will charge you the full cost of the time of the employee who performs the service, plus the full cost of any machine time and materials that the employee uses.

(7) *Billing exceeds cost of service.* Generally we will not charge you a fee when the cost of the service is less than the cost of sending you a bill. However, where an individual, organization, or governmental unit makes multiple separate requests, we will total the costs incurred and bill the requester for the services rendered.

(d) *Fee for copies of printed materials.* When extra copies of printed material are available, the charge is generally 1 cent per page. If the material may be purchased from the Superintendent of Documents, the charge is that set by the Superintendent. The Superintendent's address is in § 402.40.

(e) *Charging when requested record not found.* We may charge you for search time, even though we fail to find the records. We may also charge you for search time if the records we locate are exempt from disclosure.

§ 402.180 Procedure on assessing and collecting fees for providing records.

(a) We will generally assume that when you send us a request, you agree to pay for the services needed to locate and send that record to you. You may specify in your request a limit on the amount you are willing to spend. If you do that or include with your request a payment that does not cover our fee, we will notify you if it appears that the fee will exceed that amount and ask whether you want us to continue to process your request. Also, before we start work on your request under § 402.120, we will generally notify you of our exact or estimated charge for the information, unless it is clear that you have a reasonable idea of the cost.

(b) If you have failed to pay previous bills in a timely fashion, or if our initial review of your request indicates that we will charge you fees exceeding $250, we will require you to pay your past due fees and/or the estimated fees, or a deposit, before we start searching for the records you want. If so, we will let you know promptly upon receiving your request. In such cases, administrative time limits (i.e., ten working days from receipt of initial requests and 20 working days from receipt of appeals from initial denials, plus permissible extensions of these time limits) will begin only after we come to an agreement with you over payment of fees, or decide that fee waiver or reduction is appropriate.

(c) We will normally require you to pay all fees before we furnish the records to you. We may, at our discretion, send you a bill along with or following the furnishing of the records. For example, we may do this if you have a history of prompt payment. We may also, at our discretion, aggregate the charges for certain time periods in order to avoid sending numerous small

bills to frequent requesters, or to businesses or agents representing requesters. For example, we might send a bill to such a requester once a month. Fees should be paid in accordance with the instructions furnished by the person who responds to your requests.

(d) Payment of fees will be made by check or money order payable to ''Social Security Administration''.

§ 402.185 Waiver or reduction of fees in the public interest.

(a) *Standard.* We will waive or reduce the fees we would otherwise charge if disclosure of the information meets both tests which are explained in paragraphs (b) and (c) of this section:

(1) It is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government; and

(2) It is not primarily in the commercial interest of the requester.

(b) *Public interest.* The disclosure passes the first test only if it furthers the specific public interest of being likely to contribute significantly to public understanding of government operations or activities, regardless of any other public interest it may further. In analyzing this question, we will consider the following factors:

(1) How, if at all, do the records to be disclosed pertain to the operations or activities of the Federal Government?

(2) Would disclosure of the records reveal any meaningful information about government operations or activities? Can one learn from these records anything about such operations that is not already public knowledge?

(3) Will the disclosure advance the understanding of the general public as distinguished from a narrow segment of interested persons? Under this factor we may consider whether the requester is in a position to contribute to public understanding. For example, we may consider whether the requester has such knowledge or expertise as may be necessary to understand the information, and whether the requester's intended use of the information would be likely to disseminate the information among the public. An unsupported claim to be doing research for a book or article does not demonstrate that likelihood, while such a claim by a representative of the news media is better evidence.

(4) Will the contribution to public understanding be a significant one? Will the public's understanding of the government's operations be substantially greater as a result of the disclosure?

(c) *Not primarily in the requester's commercial interest.* If the disclosure passes the test of furthering the specific public interest described in paragraph (b) of this section, we will determine whether it also furthers the requester's commercial interest and, if so, whether this effect outweighs the advancement of that public interest. In applying this second test, we will consider the following factors:

(1) Would the disclosure further a commercial interest of the requester, or of someone on whose behalf the requester is acting? ''Commercial interests'' include interests relating to business, trade, and profit. Not only profit-making corporations have commercial interests—so do nonprofit corporations, individuals, unions, and other associations. The interest of a representative of the news media in using the information for news dissemination purposes will not be considered a commercial interest.

(2) If disclosure would further a commercial interest of the requester, would that effect outweigh the advancement of the public interest defined in paragraph (b) of this section? Which effect is primary?

(d) *Deciding between waiver and reduction.* If the disclosure passes both tests, we will normally waive fees. However, in some cases we may decide only to reduce the fees. For example, we may do this when disclosure of some but not all of the requested records passes the tests.

(e) *Procedure for requesting a waiver or reduction.* You must make your request for a waiver or reduction at the same time you make your request for records. You should explain why you believe a waiver or reduction is proper under the analysis in paragraphs (a) through (d) of this section. Only FOI Officers may make the decision whether to waive, or reduce, the fees. If we do not completely grant your request for a waiver or reduction, the denial letter

will designate a review official. You may appeal the denial to that official. In your appeal letter, you should discuss whatever reasons are given in our denial letter. The process prescribed in § 402.190 of this part will also apply to these appeals.

§ 402.190 Officials who may deny a request for records under FOIA.

Only the Director, Office of Disclosure Policy, SSA, or her or his designee is authorized to deny a written request to obtain, inspect, or copy any social security record.

§ 402.195 How a request is denied.

(a) *Oral requests.* If we cannot comply with your oral request because the Director of the Office of Disclosure Policy (or designee) has not previously made a determination to release the record you want, we will tell you that fact. If you still wish to pursue your request, you must put your request in writing.

(b) *Written requests.* If you make a written request and the information or record you requested will not be released, we will send you an official denial in writing. We will explain why the request was denied (for example, the reasons why the requested document is subject to one or more clearly described exemptions), will include the name and title or position of the person who made the decision, and what your appeal rights are.

(c) *Unproductive searches.* We make a diligent search for records to satisfy your request. Nevertheless, we may not be able always to find the records you want using the information you provided, or they may not exist. If we advise you that we have been unable to find the records despite a diligent search, this does not constitute a denial of your request.

§ 402.200 How to appeal a decision denying all or part of a request.

(a) *How to appeal.* If all or part of your written request was denied, you may request that the Commissioner of Social Security, 6401 Security Boulevard, Baltimore, MD 21235 review that determination. Your request for review:

(1) Must be in writing;

(2) Must be mailed within 30 days after you received notification that all or part of your request was denied or, if later, 30 days after you received materials in partial compliance with your request; and

(3) May include additional information or evidence to support your request.

(b) *How the review is made.* After reviewing the prior decision and after considering anything else you have submitted, the Commissioner or his or her designee will affirm or revise all or part of the prior decision. The Commissioner (or a designee) will affirm a denial only after consulting with the appropriate SSA official(s), including legal counsel. The decision must be made within 20 working days after your appeal is received. The Commissioner or a designee may extend this time limit up to 10 additional working days if one of the situations in § 402.140(a) exists, provided that, if a prior extension was used to process this request, the sum of the extensions may not exceed 10 working days. You will be notified in writing of any extension, the reason for the extension, and the date by which your appeal will be decided.

(c) *How you are notified of the Commissioner's decision.* The Commissioner or a designee will send you a written notice of the decision explaining the basis of the decision (for example, the reasons why an exemption applies) which will include the name and title or position of the person who made the decision. The notice will tell you that if any part of your request remains unsatisfied, you have the right to seek court review.

§ 402.205 U.S. District Court action.

If the Commissioner or a designee, upon review, affirms the denial of your request for records, in whole or in part, you may ask a U.S. District Court to review that denial. See 5 U.S.C. 552(a)(4)(B). If we fail to act on your request for a record or for review of a denial of such a request within the time limits in § 402.140(a) or in § 402.190(b), you may ask a U.S. District Court to treat this as if the Commissioner had denied your request.

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

Subpart A—Introduction, General Provisions and Definitions

Sec.
404.1 Introduction.
404.2 General definitions and use of terms.
404.3 General provisions.

Subpart B—Insured Status and Quarters of Coverage

GENERAL

404.101 Introduction.
404.102 Definitions.

FULLY INSURED STATUS

404.110 How we determine fully insured status.
404.111 When we consider a person fully insured based on World War II active military or naval service.
404.112 When we consider certain employees of private nonprofit organizations to be fully insured.
404.115 Table for determining the quarters of coverage you need to be fully insured.

CURRENTLY INSURED STATUS

404.120 How we determine currently insured status.

DISABILITY INSURED STATUS

404.130 How we determine disability insured status.
404.131 When you must have disability insured status.
404.132 How we determine fully insured status for a period of disability or disability insurance benefits.
404.133 When we give you quarters of coverage based on military service to establish a period of disability.

QUARTERS OF COVERAGE

404.140 What is a quarter of coverage.
404.141 How we credit quarters of coverage for calendar years before 1978.
404.142 How we credit self-employment income to calendar quarters for taxable years beginning before 1978.
404.143 How we credit quarters of coverage for calendar years after 1977.
404.144 How we credit self-employment income to calendar years for taxable years beginning after 1977.
404.145 When you acquire a quarter of coverage.
404.146 When a calendar quarter cannot be a quarter of coverage.

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

Subpart C—Computing Primary Insurance Amounts

GENERAL

404.201 Introduction.
404.202 Other regulations related to this subpart.
404.203 Definitions.
404.204 Methods of computing primary insurance amounts—general.

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

404.210 Average-indexed-monthly-earnings method.
404.211 Computing your average indexed monthly earnings.
404.212 Computing your primary insurance amount from your average indexed monthly earnings.
404.213 Computation where you are eligible for a pension based on your noncovered employment.

AVERAGE-MONTHLY-WAGE METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

404.220 Average-monthly-wage method.
404.221 Computing your average monthly wage.
404.222 Use of benefit table in finding your primary insurance amount from your average monthly wage.

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

404.230 Guaranteed alternative.
404.231 Steps in computing your primary insurance amount under the guaranteed alternative—general.
404.232 Computing your average monthly wage under the guaranteed alternative.
404.233 Adjustment of your guaranteed alternative when you become entitled after age 62.

OLD-START METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

404.240 Old-start method—general.
404.241 1977 simplified old-start method.
404.242 Use of old-start primary insurance amount as guaranteed alternative.
404.243 Computation where you are eligible for a pension based on noncovered employment.

SPECIAL COMPUTATION RULES FOR PEOPLE WHO HAD A PERIOD OF DISABILITY

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

404.251 Subsequent entitlement to benefits less than 12 months after entitlement to disability benefits ended.
404.252 Subsequent entitlement to benefits 12 months or more after entitlement to disability benefits ended.

SPECIAL MINIMUM PRIMARY INSURANCE AMOUNTS

404.260 Special minimum primary insurance amounts.
404.261 Computing your special minimum primary insurance amount.

COST-OF-LIVING INCREASES

404.270 Cost-of-living increases.
404.271 When automatic cost-of-living increases apply.
404.272 Indexes we use to measure the rise in the cost–of–living.
404.273 When automatic cost-of-living increases are to be made.
404.274 Measuring the increase in the indexes.
404.275 Amount of automatic cost-of-living increases.
404.276 Publication of notice of increase.
404.277 Automatic increases of ''frozen'' minimum primary insurance amount.
404.278 Additional cost–of–living increase.

RECOMPUTING YOUR PRIMARY INSURANCE AMOUNT

404.280 Recomputations.
404.281 Why your primary insurance amount may be recomputed.
404.282 Effective date of recomputations.
404.283 Recomputation under method other than that used to find your primary insurance amount.
404.284 Recomputations for people who reach age 62, or become disabled, or die before age 62 after 1978.
404.285 Recomputations performed automatically.
404.286 How to request an immediate recomputation.
404.287 Waiver of recomputation.
404.288 Recomputing when you are entitled to a monthly pension based on noncovered employment.

RECALCULATIONS OF PRIMARY INSURANCE AMOUNTS

404.290 Recalculations.

APPENDIX I TO SUBPART C—AVERAGE OF THE TOTAL WAGES FOR YEARS AFTER 1950
APPENDIX II TO SUBPART C—BENEFIT FORMULAS USED WITH AVERAGE INDEXED MONTHLY EARNINGS
APPENDIX III TO SUBPART C—BENEFIT TABLE
APPENDIX IV TO SUBPART C—EARNINGS NEEDED FOR A YEAR OF COVERAGE AFTER 1950
APPENDIX V TO SUBPART C—COMPUTING THE SPECIAL MINIMUM PRIMARY INSURANCE AMOUNT AND RELATED MAXIMUM FAMILY BENEFITS
APPENDIX VI TO SUBPART C—PERCENTAGE OF AUTOMATIC INCREASES IN PRIMARY INSURANCE AMOUNTS SINCE 1978
APPENDIX VII TO SUBPART C—''OLD-LAW'' CONTRIBUTION AND BENEFIT BASE

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

GENERAL

404.301 Introduction.
404.302 Other regulations related to this subpart.
404.303 Definitions.
404.304 General rules on benefit amounts.
404.305 When you may not be entitled to benefits.

OLD-AGE AND DISABILITY BENEFITS

404.310 Who is entitled to old-age benefits.
404.311 When entitlement to old-age benefits begins and ends.
404.312 Old-age benefit amounts.
404.313 Using delayed retirement credit to increase old–age benefit amount.
404.315 Who is entitled to disability benefits.
404.316 When entitlement to disability benefits begins and ends.
404.317 Disability benefit amounts.
404.320 Who is entitled to a period of disability.
404.321 When a period of disability begins and ends.
404.322 When you may apply for a period of disability after a delay due to a physical or mental condition.
404.325 The termination month.

BENEFITS FOR SPOUSES AND DIVORCED SPOUSES

404.330 Who is entitled to wife's or husband's benefits.
404.331 Who is entitled to wife's or husband's benefits as a divorced spouse.
404.332 When wife's and husband's benefits begin and end.
404.333 Wife's and husband's benefit amounts.
404.335 Who is entitled to widow's or widower's benefits.
404.336 Who is entitled to widow's or widower's benefits as a surviving divorced spouse.
404.337 When widow's and widower's benefits begin and end.
404.338 Widow's and widower's benefits amounts.
404.339 Who is entitled to mother's or father's benefits.
404.340 Who is entitled to mother's or father's benefits as a surviving divorced spouse.

404.341 When mother's and father's benefits begin and end.
404.342 Mother's and father's benefit amounts.
404.344 Your relationship by marriage to the insured.
404.345 Your relationship as wife, husband, widow, or widower under State law.
404.346 Your relationship as wife, husband, widow, or widower based upon a deemed valid marriage.
404.347 ''Living in the same household'' defined.
404.348 When a child living with you is ''in your care''.
404.349 When a child living apart from you is ''in your care''.

CHILD'S BENEFITS

404.350 Who is entitled to child's benefits.
404.351 Who may be reentitled to child's benefits.
404.352 When child's benefits begin and end.
404.353 Child's benefit amounts.
404.354 Your relationship to the insured.
404.355 Who is the insured's natural child.
404.356 Who is the insured's legally adopted child.
404.357 Who is the insured's stepchild.
404.358 Who is the insured's grandchild or stepgrandchild.
404.359 Who is the insured's equitably adopted child.
404.360 When a child is dependent upon the insured person.
404.361 When a natural child is dependent.
404.362 When a legally adopted child is dependent.
404.363 When a stepchild is dependent.
404.364 When a grandchild or stepgrandchild is dependent.
404.365 When an equitably adopted child is dependent.
404.366 ''Contributions for support,'' ''one-half support,'' and ''living with'' the insured defined—determining first month of entitlement.
404.367 When you are a ''full-time elementary or secondary school student''.
404.368 When you are considered a full-time student during a period of nonattendance.

PARENT'S BENEFITS

404.370 Who is entitled to parent's benefits.
404.371 When parent's benefits begin and end.
404.373 Parent's benefit amounts.
404.374 Parent's relationship to the insured.

SPECIAL PAYMENTS AT AGE 72

404.380 General.
404.381 Who is entitled to special age 72 payments.
404.382 When special age 72 payments begin and end.
404.383 Special age 72 payment amounts.
404.384 Reductions, suspensions, and nonpayments of special age 72 payments.

LUMP-SUM DEATH PAYMENT

404.390 General.
404.391 Who is entitled to the lump-sum death payment as a widow or widower who was living in the same household.
404.392 Who is entitled to the lump-sum death payment when there is no widow(er) who was living in the same household.

Subpart E—Deductions; Reductions; and Nonpayments of Benefits

404.401 Deduction, reduction, and nonpayment of monthly benefits or lump-sum death payments.
404.401a When we do not pay benefits because of a disability beneficiary's work activity.
404.402 Interrelationship of deductions, reductions, adjustments, and nonpayment of benefits.
404.403 Reduction where total monthly benefits exceed maximum family benefits payable.
404.404 How reduction for maximum affects insured individual and other persons entitled on his earnings record.
404.405 Situations where total benefits can exceed maximum because of ''savings clause.''
404.406 Reduction for maximum because of retroactive effect of application for monthly benefits.
404.407 Reduction because of entitlement to other benefits.
404.408 Reduction of benefits based on disability on account of receipt of certain other disability benefits provided under Federal, State, or local laws or plans.
404.408a Reduction where spouse is receiving a Government pension.
404.408b Reduction of retroactive monthly social security benefits where supplemental security income (SSI) payments were received for the same period.
404.409 [Reserved]
404.410 Reduction in benefits for age—general.
404.411 Special reduction in benefits for age involving entitlement to two or more benefits.
404.412 Adjustments in benefit reductions for age.
404.413 Reduction in benefits for age following an increase in primary insurance amounts.
404.415 Deductions because of excess earnings; annual earnings test.
404.416 Amount of deduction because of excess earnings.

404.417 Deductions because of noncovered remunerative activity outside the United States; 45 hour and 7-day work test.
404.418 ''Noncovered remunerative activity outside the United States,'' defined.
404.420 Persons deemed entitled to benefits based on an individual's earnings record.
404.421 Deductions because beneficiary failed to have a child in his or her care.
404.422 Deductions because of refusal to accept rehabilitation services.
404.423 Manner of making deductions.
404.424 Total amount of deductions where more than one deduction event occurs in a month.
404.425 Total amount of deductions where deduction events occur in more than 1 month.
404.428 Earnings in a taxable year.
404.429 Earnings; defined.
404.430 Excess earnings defined for taxable years ending after December 1972; monthly exempt amount defined.
404.434 Excess earnings; method of charging.
404.435 Excess earnings; months to which excess earnings cannot be charged.
404.436 Excess earnings; months to which excess earnings cannot be charged because individual is deemed not entitled to benefits.
404.437 Excess earnings; benefit rate subject to deductions because of excess earnings.
404.439 Partial monthly benefits; excess earnings of the individual charged against his benefits and the benefits of persons entitled (or deemed entitled) to benefits on his earnings record.
404.440 Partial monthly benefits; prorated share of partial payment exceeds the benefit before deduction for excess earnings.
404.441 Partial monthly benefits; insured individual and another person entitled (or deemed entitled) on the same earnings record both have excess earnings.
404.446 Definition of ''substantial services'' and ''services''.
404.447 Evaluation of factors involved in substantial services test.
404.450 Required reports of work outside the United States or failure to have care of a child.
404.451 Penalty deductions for failure to report within prescribed time limit noncovered remunerative activity outside the United States or not having care of a child.
404.452 Reports to Social Security Administration of earnings; wages; net earnings from self-employment.
404.453 Penalty deductions for failure to report earnings timely.
404.454 Good cause for failure to make required reports.
404.455 Request by Social Security Administration for reports of earnings and estimated earnings; effect of failure to comply with request.
404.456 Current suspension of benefits because an individual works or engages in self-employment.
404.457 Deductions where taxes neither deducted from wages of certain maritime employees nor paid.
404.458 Limiting deductions where total family benefits payable would not be affected or would be only partly affected.
404.460 Nonpayment of monthly benefits of aliens outside the United States.
404.461 Nonpayment of lump sum after death of alien outside United States for more than 6 months.
404.462 Nonpayment of hospital and medical insurance benefits of alien outside United States for more than 6 months.
404.463 Nonpayment of benefits of aliens outside the United States; ''foreign social insurance system,'' and ''treaty obligation'' exceptions defined.
404.464 Nonpayment of benefits where individual is deported; prohibition against payment of lump sum based on deported individual's earnings records.
404.465 Conviction for subversive activities; effect on monthly benefits and entitlement to hospital insurance benefits.
404.466 Conviction for subversive activities; effect on enrollment for supplementary medical insurance benefits.
404.467 Nonpayment of benefits; individual entitled to disability insurance benefits or childhood disability benefits based on statutory blindness is engaging in substantial gainful activity.
404.468 Nonpayment of benefits to prisoners.
404.469 Nonpayment of benefits where individual has not furnished or applied for a Social Security number.
404.470 Nonpayment of disability benefits due to noncompliance with rules regarding treatment for drug addiction or alcoholism.
404.480 Paying benefits in installments: Drug addiction or alcoholism.

Subpart F—Overpayments, Underpayments, Waiver of Adjustment or Recovery of Overpayments, and Liability of a Certifying Officer

404.501 General applicability of section 204 of the Act.
404.502 Overpayments.
404.502a Notice of right to waiver consideration.
404.503 Underpayments.
404.504 Relation to provisions for reductions and increases.
404.505 Relationship to provisions requiring deductions.
404.506 When waiver may be applied and how to process the request.
404.507 Fault.

404.508 Defeat the purpose of Title II.
404.509 Against equity and good conscience; defined.
404.510 When an individual is ''without fault'' in a deduction overpayment.
404.510a When an individual is ''without fault'' in an entitlement overpayment.
404.511 When an individual is at ''fault'' in a deduction overpayment.
404.512 When adjustment or recovery of an overpayment will be waived.
404.513 Liability of a certifying officer.
404.515 Collection and compromise of claims for overpayment.
404.520 Referral of overpayments to the Department of the Treasury for tax refund offset—General.
404.521 Notice to overpaid individual.
404.522 Review within SSA that an overpayment is past due and legally enforceable.
404.523 Findings by SSA.
404.524 Review of our records related to the overpayment.
404.525 Suspension of offset.
404.526 Tax refund insufficient to cover amount of overpayment.
404.527 Additional methods for recovery of title II benefit overpayments.

Subpart G—Filing of Applications and Other Forms

GENERAL PROVISIONS

404.601 Introduction.
404.602 Definitions.
404.603 You must file an application to receive benefits.

APPLICATIONS

404.610 What makes an application a claim for benefits.
404.611 Filing of application with Social Security Administration.
404.612 Who may sign an application.
404.613 Evidence of authority to sign an application for another.
404.614 When an application or other form is considered filed.
404.615 Claimant must be alive when an application is filed.

EFFECTIVE FILING PERIOD OF APPLICATION

404.620 Filing before the first month you meet the requirements for benefits.
404.621 Filing after the first month you meet the requirements for benefits.
404.622 Limiting an application.
404.623 Filing by person eligible for old-age and husband's or wife's benefits.

FILING DATE BASED ON WRITTEN STATEMENT

404.630 Use of date of written statement as filing date.
404.631 Statements filed with the Railroad Retirement Board.
404.632 Statements filed with a hospital.

DEEMED FILING DATE BASED ON MISINFORMATION

404.633 Deemed filing date in a case of misinformation.

WITHDRAWAL OF APPLICATION

404.640 Withdrawal of an application.
404.641 Cancellation of a request to withdraw.

Subpart H—Evidence

GENERAL

404.701 Introduction.
404.702 Definitions.
404.703 When evidence is needed.
404.704 Your responsibility for giving evidence.
404.705 Failure to give requested evidence.
404.706 Where to give evidence.
404.707 Original records or copies as evidence.
404.708 How we decide what is enough evidence.
404.709 Preferred evidence and other evidence.

EVIDENCE OF AGE, MARRIAGE, AND DEATH

404.715 When evidence of age is needed.
404.716 Type of evidence of age to be given.
404.720 Evidence of a person's death.
404.721 Evidence to presume a person is dead.
404.722 Rebuttal of a presumption of death.
404.723 When evidence of marriage is required.
404.725 Evidence of a valid ceremonial marriage.
404.726 Evidence of common-law marriage.
404.727 Evidence of a deemed valid marriage.
404.728 Evidence a marriage has ended.

EVIDENCE FOR CHILD'S AND PARENT'S BENEFITS

404.730 When evidence of a parent or child relationship is needed.
404.731 Evidence you are a natural parent or child.
404.732 Evidence you are a stepparent or stepchild.
404.733 Evidence you are the legally adopting parent or legally adopted child.
404.734 Evidence you are an equitably adopted child.
404.735 Evidence you are the grandchild or stepgrandchild.
404.736 Evidence of a child's dependency.
404.745 Evidence of school attendance for child age 18 or older.
404.750 Evidence of a parent's support.

OTHER EVIDENCE REQUIREMENTS

404.760 Evidence of living in the same household with insured person.

404.762 Evidence of having a child in your care.
404.770 Evidence of where the insured person had a permanent home.
404.780 Evidence of ''good cause'' for exceeding time limits on accepting proof of support or application for a lump-sum death payment.

Subpart I—Records of Earnings

GENERAL PROVISIONS

404.801 Introduction.
404.802 Definitions.
404.803 Conclusiveness of the record of your earnings.

OBTAINING EARNINGS INFORMATION

404.810 How to obtain a statement of earnings and a benefit estimate statement.
404.811 The statement of earnings and benefit estimates you requested.
404.812 Statement of earnings and benefit estimates sent without request.

CORRECTING THE EARNINGS RECORD

404.820 Filing a request for correction of the record of your earnings.
404.821 Correction of the record of your earnings before the time limit ends.
404.822 Correction of the record of your earnings after the time limit ends.
404.823 Correction of the record of your earnings for work in the employ of the United States.

NOTICE OF REMOVAL OR REDUCTION OF AN ENTRY OF EARNINGS

404.830 Notice of removal or reduction of your wages.
404.831 Notice of removal or reduction of your self-employment income.

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

404.900 Introduction.
404.901 Definitions.
404.902 Administrative actions that are initial determinations.
404.903 Administrative actions that are not initial determinations.
404.904 Notice of the initial determination.
404.905 Effect of an initial determination.
404.906 Testing modifications to the disability determination procedures.

RECONSIDERATION

404.907 Reconsideration—general.
404.908 Parties to a reconsideration.
404.909 How to request reconsideration.
404.911 Good cause for missing the deadline to request review.
404.913 Reconsideration procedures.
404.914 Disability hearing—general.
404.915 Disability hearing—disability hearing officers.
404.916 Disability hearing—procedures.
404.917 Disability hearing—disability hearing officer's reconsidered determination.
404.918 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.
404.919 Notice of another person's request for reconsideration.
404.920 Reconsidered determination.
404.921 Effect of a reconsidered determination.
404.922 Notice of a reconsidered determination.

EXPEDITED APPEALS PROCESS

404.923 Expedited appeals process—general.
404.924 When the expedited appeals process may be used.
404.925 How to request expedited appeals process.
404.926 Agreement in expedited appeals process.
404.927 Effect of expedited appeals process agreement.
404.928 Expedited appeals process request that does not result in agreement.

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

404.929 Hearing before an administrative law judge—general.
404.930 Availability of a hearing before an administrative law judge.
404.932 Parties to a hearing before an administrative law judge.
404.933 How to request a hearing before an administrative law judge.
404.935 Submitting evidence prior to a hearing before an administrative law judge.
404.936 Time and place for a hearing before an administrative law judge.
404.938 Notice of a hearing before an administrative law judge.
404.939 Objections to the issues.
404.940 Disqualification of the administrative law judge.
404.941 Prehearing case review.
404.942 Prehearing proceedings and decisions by attorney advisors.
404.943 Responsibilities of the adjudication officer.

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

404.944 Administrative law judge hearing procedures—general.
404.946 Issues before an administrative law judge.

404.948 Deciding a case without an oral hearing before an administrative law judge.
404.949 Presenting written statements and oral arguments.
404.950 Presenting evidence at a hearing before an administrative law judge.
404.951 When a record of a hearing before an administrative law judge is made.
404.952 Consolidated hearing before an administrative law judge.
404.953 The decision of an administrative law judge.
404.955 The effect of an administrative law judge's decision.
404.956 Removal of a hearing request from an administrative law judge to the Appeals Council.
404.957 Dismissal of a request for a hearing before an administrative law judge.
404.958 Notice of dismissal of a request for a hearing before an administrative law judge.
404.959 Effect of dismissal of a request for a hearing before an administrative law judge.
404.960 Vacating a dismissal of a request for a hearing before an administrative law judge.
404.961 Prehearing and posthearing conferences.
404.965 [Reserved]

APPEALS COUNCIL REVIEW

404.966 Testing elimination of the request for Appeals Council review.
404.967 Appeals Council review—general.
404.968 How to request Appeals Council review.
404.969 Appeals Council initiates review.
404.970 Cases the Appeals Council will review.
404.971 Dismissal by Appeals Council.
404.972 Effect of dismissal of request for Appeals Council review.
404.973 Notice of Appeals Council review.
404.974 Obtaining evidence from Appeals Council.
404.975 Filing briefs with the Appeals Council.
404.976 Procedures before Appeals Council on review.
404.977 Case remanded by Appeals Council.
404.979 Decision of Appeals Council.
404.981 Effect of Appeals Council's decision or denial of review.
404.982 Extension of time to file action in Federal district court.

COURT REMAND CASES

404.983 Case remanded by a Federal court.
404.984 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.
404.985 Application of circuit court law.

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

404.987 Reopening and revising determinations and decisions.
404.988 Conditions for reopening.
404.989 Good cause for reopening.
404.990 Finality of determinations and decisions on revision of an earnings record.
404.991 Finality of determinations and decisions to suspend benefit payments for entire taxable year because of earnings.
404.991a Late completion of timely investigation.
404.992 Notice of revised determination or decision.
404.993 Effect of revised determination or decision.
404.994 Time and place to request a hearing on revised determination or decision.
404.995 Finality of findings when later claim is filed on same earnings record.
404.996 Increase in future benefits where time period for reopening expires.

PAYMENT OF CERTAIN TRAVEL EXPENSES

404.999a Payment of certain travel expenses—general.
404.999b Who may be reimbursed.
404.999c What travel expenses are reimbursable.
404.999d When and how to claim reimbursement.

Subpart K—Employment, Wages, Self-Employment, and Self-Employment Income

404.1001 Introduction.
404.1002 Definitions.

EMPLOYMENT

404.1003 Employment.
404.1004 What work is covered as employment.
404.1005 Who is an employee.
404.1006 Corporation officer.
404.1007 Common-law employee.
404.1008 Agent-driver or commission-driver, full-time life insurance salesman, home worker, or traveling or city salesman.
404.1009 Who is an employer.
404.1010 Farm crew leader as employer.

WORK EXCLUDED FROM EMPLOYMENT

404.1012 Work excluded from employment.
404.1013 Included-excluded rule.
404.1014 Domestic service by a student for a local college club, fraternity or sorority.
404.1015 Family services.
404.1016 Foreign agricultural workers.
404.1017 Sharefarmers.
404.1018 Work by civilians for the United States Government or its instrumentalities—wages paid after 1983.
404.1018a Work by civilians for the United States Government or its instrumentalities—remuneration paid prior to 1984.

404.1018b Medicare qualified government employment.
404.1019 Work as a member of a uniformed service of the United States.
404.1020 Work for States and their political subdivisions and instrumentalities.
404.1021 Work for the District of Columbia.
404.1022 American Samoa or Guam.
404.1023 Ministers of churches and members of religious orders.
404.1024 Election of coverage by religious orders.
404.1025 Work for religious, charitable, educational, or certain other organizations exempt from income tax.
404.1026 Work for a church or qualified church–controlled organization.
404.1027 Railroad work.
404.1028 Student working for a school, college, or university.
404.1029 Student nurses.
404.1030 Delivery and distribution or sale of newspapers, shopping news, and magazines.
404.1031 Fishing.
404.1032 Work for a foreign government.
404.1033 Work for a wholly owned instrumentality of a foreign government.
404.1034 Work for an international organization.
404.1035 Work for a communist organization.
404.1036 Certain nonresident aliens.
404.1037 Work on or in connection with a non-American vessel or aircraft.
404.1038 Domestic employees under age 18.

EXEMPTION FROM SOCIAL SECURITY BY REASON OF RELIGOUS BELIEF

404.1039 Employers (including partnerships) and employees who are both members of certain religious groups opposed to insurance.

WAGES

404.1041 Wages.
404.1042 Wages when paid and received.
404.1043 Facilities or privileges—meals and lodging.
404.1044 Vacation pay.
404.1045 Employee expenses.
404.1046 Pay for work by certain members of religious orders.
404.1047 Annual wage limitation.
404.1048 Contribution and benefit base after 1992.
404.1049 Payments under an employer plan or system.
404.1050 Retirement payments.
404.1051 Payments on account of sickness or accident disability, or related medical or hospitalization expenses.
404.1052 Payments from or to certain tax-exempt trusts or payments under or into certain annuity plans.
404.1053 ''Qualified benefits'' under a cafeteria plan.
404.1054 Payments by an employer of employee's tax or employee's contribution under State law.
404.1055 Payments for agricultural labor.
404.1056 Explanation of agricultural labor.
404.1057 Domestic service in the employer's home.
404.1058 Special situations.
404.1059 Deemed wages for certain individuals interned during World War II.
404.1060 [Reserved]

SELF-EMPLOYMENT

404.1065 Self-employment coverage.
404.1066 Trade or business in general.
404.1068 Employees who are considered self-employed.
404.1069 Real estate agents and direct sellers.
404.1070 Christian Science practitioners.
404.1071 Ministers and members of religious orders.
404.1073 Public office.
404.1074 Farm crew leader who is self-employed.
404.1075 Members of certain religious groups opposed to insurance.
404.1077 Individuals under railroad retirement system.

SELF-EMPLOYMENT INCOME

404.1080 Net earnings from self-employment.
404.1081 General rules for figuring net earnings from self-employment.
404.1082 Rentals from real estate; material participation.
404.1083 Dividends and interest.
404.1084 Gain or loss from disposition of property; capital assets; timber, coal, and iron ore; involuntary conversion.
404.1085 Net operating loss deduction.
404.1086 Community income.
404.1087 Figuring partner's net earnings from self-employment for taxable year which ends as a result of death.
404.1088 Retirement payment to retired partners.
404.1089 Figuring net earnings for residents and nonresidents of Puerto Rico.
404.1090 Personal exemption deduction.
404.1091 Figuring net earnings for ministers and members of religious orders.
404.1092 Figuring net earnings for U.S. citizens or residents living outside the United States.
404.1093 Possession of the United States.
404.1094 Options available for figuring net earnings from self-employment.
404.1095 Agricultural trade or business.
404.1096 Self-employment income.

Subpart L [Reserved]

Subpart M—Coverage of Employees of State and Local Governments

GENERAL

404.1200 General.
404.1201 Scope of this subpart regarding coverage and wage reports and adjustments.
404.1202 Definitions.
404.1203 Evidence—for wages paid prior to 1987.
404.1204 Designating officials to act on behalf of the State.

WHAT GROUPS OF EMPLOYEES MAY BE COVERED

404.1205 Absolute coverage groups.
404.1206 Retirement system coverage groups.
404.1207 Divided retirement system coverage groups.
404.1208 Ineligible employees.
404.1209 Mandatorily excluded services.
404.1210 Optionally excluded services.
404.1211 Interstate instrumentalities.
404.1212 Police officers and firefighters.

HOW COVERAGE UNDER AGREEMENTS IS OBTAINED AND CONTINUES

404.1214 Agreement for coverage.
404.1215 Modification of agreement.
404.1216 Modification of agreement to correct an error.
404.1217 Continuation of coverage.
404.1218 Resumption of coverage.
404.1219 Dissolution of political subdivision.

HOW TO IDENTIFY COVERED EMPLOYEES

404.1220 Identification numbers.

WHAT RECORDS OF COVERAGE MUST BE KEPT

404.1225 Records—for wages paid prior to 1987.

REVIEW OF COMPLIANCE BY STATE WITH ITS AGREEMENT

404.1230 Onsite review program.
404.1231 Scope of review.
404.1232 Conduct of review.
404.1234 Reports of review's findings.

HOW TO REPORT WAGES AND CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

404.1237 Wage reports and contribution returns—general—for wages paid prior to 1987.
404.1239 Wage reports for employees performing services in more than one coverage group—for wages paid prior to 1987.
404.1242 Back pay.
404.1243 Use of reporting forms—for wages paid prior to 1987.
404.1247 When to report wages—for wages paid prior to 1987.
404.1249 When and where to make deposits of contributions and to file contribution returns and wage reports—for wages paid prior to 1987.
404.1251 Final reports—for wages paid prior to 1987.

WHAT IS A STATE'S LIABILITY FOR CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

404.1255 State's liability for contributions—for wages paid prior to 1987.
404.1256 Limitation on State's liability for contributions for multiple employment situations—for wages paid prior to 1987.

FIGURING THE AMOUNT OF THE STATE'S CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

404.1260 Amount of contributions—for wages paid prior to 1987.
404.1262 Manner of payment of contributions by State—for wages paid prior to 1987.
404.1263 When fractional part of a cent may be disregarded—for wages paid prior to 1987.

IF A STATE FAILS TO MAKE TIMELY PAYMENTS—FOR WAGES PAID PRIOR TO 1987

404.1265 Addition of interest to contributions—for wages paid prior to 1987.
404.1267 Failure to make timely payments—for wages paid prior to 1987.

HOW ERRORS IN REPORTS AND CONTRIBUTIONS ARE ADJUSTED—FOR WAGES PAID PRIOR TO 1987

404.1270 Adjustments in general—for wages paid prior to 1987.
404.1271 Adjustment of overpayment of contributions—for wages paid prior to 1987.
404.1272 Refund or recomputation of overpayments which are not adjustable—for wages paid prior to 1987.
404.1275 Adjustment of employee contributions—for wages paid prior to 1987.
404.1276 Reports and payments erroneously made to Internal Revenue Service-transfer of funds—for wages paid prior to 1987.

HOW OVERPAYMENTS OF CONTRIBUTIONS ARE CREDITED OR REFUNDED—FOR WAGES PAID PRIOR TO 1987

404.1280 Allowance of credits or refunds—for wages paid prior to 1987.
404.1281 Credits or refunds for periods of time during which no liability exists—for wages paid prior to 1987.
404.1282 Time limitations on credits or refunds—for wages paid prior to 1987.
404.1283 Exceptions to the time limitations on credits or refunds—for wages paid prior to 1987.
404.1284 Offsetting underpayments against overpayments—for wages paid prior to 1987.

HOW ASSESSMENTS FOR UNDERPAYMENTS OF CONTRIBUTIONS ARE MADE—FOR WAGES PAID PRIOR TO 1987

404.1285 Assessments of amounts due—for wages paid prior to 1987.
404.1286 Time limitations on assessments—for wages paid prior to 1987.
404.1287 Exceptions to the time limitations on assessments—for wages paid prior to 1987.
404.1289 Payment after expiration of time limitation for assessment—for wages paid prior to 1987.

SECRETARY'S REVIEW OF DECISIONS ON CREDITS, REFUNDS, OR ASSESSMENTS—FOR WAGES PAID PRIOR TO 1987

404.1290 Review of decisions by the Secretary—for wages paid prior to 1987.
404.1291 Reconsideration—for wages paid prior to 1987.
404.1292 How to request review—for wages paid prior to 1987.
404.1293 Time for filing request for review—for wages paid prior to 1987.
404.1294 Notification to State after reconsideration—for wages paid prior to 1987.
404.1295 Commissioner's review—for wages paid prior to 1987.
404.1296 Commissioner's notification to the State—for wages paid prior to 1987.

HOW A STATE MAY SEEK COURT REVIEW OF SECRETARY'S DECISION—FOR WAGES PAID PRIOR TO 1987

404.1297 Review by court—for wages paid prior to 1987.
404.1298 Time for filing civil action—for wages paid prior to 1987.
404.1299 Final judgments—for wages paid prior to 1987.

Subpart N—Wage Credits for Veterans and Members of the Uniformed Services

GENERAL

404.1301 Introduction.
404.1302 Definitions.

WORLD WAR II VETERANS

404.1310 Who is a World War II veteran.
404.1311 Ninety-day active service requirement for World War II veterans.
404.1312 World War II service included.
404.1313 World War II service excluded.

POST-WORLD WAR II VETERANS

404.1320 Who is a post-World War II veteran.
404.1321 Ninety-day active service requirement for post-World War II veterans.
404.1322 Post-World War II service included.
404.1323 Post-World War II service excluded.

SEPARATION FROM ACTIVE SERVICE

404.1325 Separation from active service under conditions other than dishonorable.

MEMBERS OF THE UNIFORMED SERVICES

404.1330 Who is a member of a uniformed service.

AMOUNTS OF WAGE CREDITS AND LIMITS ON THEIR USE

404.1340 Wage credits for World War II and post-World War II veterans.
404.1341 Wage credits for a member of a uniformed service.
404.1342 Limits on granting World War II and post-World War II wage credits.
404.1343 When the limits on granting World War II and post-World War II wage credits do not apply.

DEEMED INSURED STATUS FOR WORLD WAR II VETERANS

404.1350 Deemed insured status.
404.1351 When deemed insured status does not apply.
404.1352 Benefits and payments based on deemed insured status.

EFFECT OF OTHER BENEFITS ON PAYMENT OF SOCIAL SECURITY BENEFITS AND PAYMENTS

404.1360 Veterans Administration pension or compensation payable.
404.1361 Federal benefit payable other than by Veterans Administration.
404.1362 Treatment of social security benefits or payments where Veterans Administration pension or compensation payable.
404.1363 Treatment of social security benefits or payments where Federal benefit payable other than by Veterans Administration.

EVIDENCE OF ACTIVE SERVICE AND MEMBERSHIP IN A UNIFORMED SERVICE

404.1370 Evidence of active service and separation from active service.
404.1371 Evidence of membership in a uniformed service during the years 1957 through 1967.

Subpart O—Interrelationship of Old-Age, Survivors and Disability Insurance Program With the Railroad Retirement Program

404.1401 General relationship of Railroad Retirement Act with the old-age, survivors and disability insurance program of the Social Security Act.
404.1402 When services in the railroad industry are covered.
404.1403 Definition of ''years of service''.

404.1404 Effective date of coverage of railroad services under the act.
404.1405 When the provisions of §404.1402 do not apply.
404.1406 Eligibility to railroad retirement benefits as a bar to payment of social security benefits.
404.1407 When railroad retirement benefits do not bar payment of social security benefits.
404.1408 Compensation to be treated as wages.
404.1409 Purposes of using compensation.
404.1410 Presumption on basis of certified compensation record.
404.1412 Compensation quarters of coverage.
404.1413 Certification of payment to Railroad Retirement Board.

Subpart P—Determining Disability and Blindness

GENERAL

404.1501 Scope of subpart.
404.1502 General definitions and terms for this subpart.

DETERMINATIONS

404.1503 Who makes disability and blindness determinations.
404.1503a Program integrity.
404.1504 Determinations by other organizations and agencies.

DEFINITION OF DISABILITY

404.1505 Basic definition of disability.
404.1506 When we will not consider your impairment.
404.1508 What is needed to show an impairment.
404.1509 How long the impairment must last.
404.1510 Meaning of substantial gainful activity.
404.1511 Definition of disabling impairment.

EVIDENCE

404.1512 Evidence of your impairment.
404.1513 Medical evidence of your impairment.
404.1514 When we will purchase existing evidence.
404.1515 Where and how to submit evidence.
404.1516 If you fail to submit medical and other evidence.
404.1517 Consultative examination at our expense.
404.1518 If you do not appear at a consultative examination.

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

404.1519 The consultative examination.
404.1519a When we will purchase a consultative examination and how we will use it.
404.1519b When we will not purchase a consultative examination.

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

404.1519f Type of purchased examinations.
404.1519g Who we will select to perform a consultative examination.
404.1519h Your treating source.
404.1519i Other sources for consultative examinations.
404.1519j Objections to the medical source designated to perform the consultative examination.
404.1519k Purchase of medical examinations, laboratory tests, and other services.
404.1519m Diagnostic tests or procedures.
404.1519n Informing the medical source of examination scheduling, report content, and signature requirements.
404.1519o When a properly signed consultative examination report has not been received.
404.1519p Reviewing reports of consultative examinations.
404.1519q Conflict of interest.

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

404.1519s Authorizing and monitoring the consultative examination.

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

404.1519t Consultative examination oversight.

EVALUATION OF DISABILITY

404.1520 Evaluation of disability in general.
404.1520a Evaluation of mental impairments.
404.1521 What we mean by an impairment(s) that is not severe.
404.1522 When you have two or more unrelated impairments—initial claims.
404.1523 Multiple impairments.

MEDICAL CONSIDERATIONS

404.1525 Listing of Impairments in appendix 1.
404.1526 Medical equivalence.
404.1527 Evaluating opinion evidence.
404.1528 Symptoms, signs, and laboratory findings.
404.1529 How we evaluate symptoms, including pain.
404.1530 Need to follow prescribed treatment.
404.1535 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

404.1536 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.
404.1537 What we mean by appropriate treatment.
404.1538 What we mean by approved institutions or facilities.
404.1539 How we consider whether treatment is available.
404.1540 Evaluating compliance with the treatment requirements.
404.1541 Establishment and use of referral and monitoring agencies.

RESIDUAL FUNCTIONAL CAPACITY

404.1545 Your residual functional capacity.
404.1546 Responsibility for assessing and determining residual functional capacity.

VOCATIONAL CONSIDERATIONS

404.1560 When your vocational background will be considered.
404.1561 Your ability to do work depends upon your residual functional capacity.
404.1562 If you have done only arduous unskilled physical labor.
404.1563 Your age as a vocational factor.
404.1564 Your education as a vocational factor.
404.1565 Your work experience as a vocational factor.
404.1566 Work which exists in the national economy.
404.1567 Physical exertion requirements.
404.1568 Skill requirements.
404.1569 Listing of Medical-Vocational Guidelines in appendix 2.
404.1569a Exertional and nonexertional limitations.

SUBSTANTIAL GAINFUL ACTIVITY

404.1571 General.
404.1572 What we mean by substantial gainful activity.
404.1573 General information about work activity.
404.1574 Evaluation guides if you are an employee.
404.1575 Evaluation guides if you are self-employed.
404.1576 Impairment-related work expenses.

WIDOWS, WIDOWERS, AND SURVIVING DIVORCED SPOUSES

404.1577 Disability defined for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.
404.1578 How we determine disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.
404.1579 How we will determine whether your disability continues or ends.

BLINDNESS

404.1581 Meaning of blindness as defined in the law.
404.1582 A period of disability based on blindness.
404.1583 How we determine disability for blind persons who are age 55 or older.
404.1584 Evaluation of work activity of blind people.
404.1585 Trial work period for persons age 55 or older who are blind.
404.1586 Why and when we will stop your cash benefits.
404.1587 Circumstances under which we may suspend your benefits before we make a determination.

CONTINUING OR STOPPING DISABILITY

404.1588 Your responsibility to tell us of events that may change your disability status.
404.1589 We may conduct a review to find out whether you continue to be disabled.
404.1590 When and how often we will conduct a continuing disability review.
404.1591 If your medical recovery was expected and you returned to work.
404.1592 The trial work period.
404.1592a The reentitlement period.
404.1593 Medical evidence in continuing disability review cases.
404.1594 How we will determine whether your disability continues or ends.
404.1595 When we determine that you are not now disabled.
404.1596 Circumstances under which we may suspend your benefits before we make a determination.
404.1597 After we make a determination that you are not now disabled.
404.1597a Continued benefits pending appeal of a medical cessation determination.
404.1598 If you become disabled by another impairment(s).
404.1599 Work incentive experiments and rehabilitation demonstration projects in the disability program.

APPENDIX 1 TO SUBPART P—LISTING OF IMPAIRMENTS
APPENDIX 2 TO SUBPART P—MEDICAL-VOCATIONAL GUIDELINES

Subpart Q—Determinations of Disability

GENERAL PROVISIONS

404.1601 Purpose and scope.
404.1602 Definitions.
404.1603 Basic responsibilities for us and the State.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

404.1610 How a State notifies us that it wishes to perform the disability determination function.

404.1611 How we notify a State whether it may perform the disability determination function.
404.1613 Disability determinations the State makes.
404.1614 Responsibilities for obtaining evidence to make disability determinations.
404.1615 Making disability determinations.
404.1616 Medical or psychological consultant.
404.1617 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.
404.1618 Notifying claimants of the disability determination.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

404.1620 General administrative requirements.
404.1621 Personnel.
404.1622 Training.
404.1623 Facilities.
404.1624 Medical and other purchased services.
404.1625 Records and reports.
404.1626 Fiscal.
404.1627 Audits.
404.1628 Property.
404.1629 Participation in research and demonstration projects.
404.1630 Coordination with other agencies.
404.1631 Confidentiality of information and records.
404.1632 Other Federal laws and regulations.
404.1633 Policies and operating instructions.

PERFORMANCE STANDARDS

404.1640 General.
404.1641 Standards of performance.
404.1642 Processing time standards.
404.1643 Performance accuracy standard.
404.1644 How and when we determine whether the processing time standards are met.
404.1645 How and when we determine whether the performance accuracy standard is met.
404.1650 Action we will take if a State agency does not meet the standards.

PERFORMANCE MONITORING AND SUPPORT

404.1660 How we will monitor.
404.1661 When we will provide performance support.
404.1662 What support we will provide.

SUBSTANTIAL FAILURE

404.1670 General.
404.1671 Good cause for not following the Act, our regulations, or other written guidelines.
404.1675 Finding of substantial failure.

HEARINGS AND APPEALS

404.1680 Notice of right to hearing on proposed finding of substantial failure.
404.1681 Disputes on matters other than substantial failure.
404.1682 Who conducts the hearings.
404.1683 Hearings and appeals process.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

404.1690 Assumption when we make a finding of substantial failure.
404.1691 Assumption when State no longer wishes to perform the disability determination function.
404.1692 Protection of State employees.
404.1693 Limitation on State expenditures after notice.
404.1694 Final accounting by the State.

Subpart R—Representation of Parties

404.1700 Introduction.
404.1703 Definitions.
404.1705 Who may be your representative.
404.1706 Notification of options for obtaining attorney representation.
404.1707 Appointing a representative.
404.1710 Authority of a representative.
404.1715 Notice or request to a representative.
404.1720 Fee for a representative's services.
404.1725 Request for approval of a fee.
404.1728 Proceedings before a State or Federal court.
404.1730 Payment of fees.
404.1735 Services in a proceeding under title II of the Act.
404.1740 Rules of conduct and standards of responsibility for representatives.
404.1745 Violations of our requirements, rules, or standards.
404.1750 Notice of charges against a representative.
404.1755 Withdrawing charges against a representative.
404.1765 Hearing on charges.
404.1770 Decision by hearing officer.
404.1775 Requesting review of the hearing officer's decision.
404.1776 Assignment of request for review of the hearing officer's decision.
404.1780 Appeals Council's review of hearing officer's decision.
404.1785 Evidence permitted on review.
404.1790 Appeals Council's decision.
404.1795 When the Appeals Council will dismiss a request for review.
404.1797 Reinstatement after suspension—period of suspension expired.
404.1799 Reinstatement after suspension or disqualification—period of suspension not expired.

Subpart S—Payment Procedures

404.1800 Introduction.
404.1805 Paying benefits.
404.1807 Monthly payment day.
404.1810 Expediting benefit payments.

404.1815 Withholding certification or payments.
404.1820 Transfer or assignment of payments.
404.1825 Joint payments to a family.

Subpart T—Totalization Agreements

GENERAL PROVISIONS

404.1901 Introduction.
404.1902 Definitions.
404.1903 Negotiating totalization agreements.
404.1904 Effective date of a totalization agreement.
404.1905 Termination of agreements.

BENEFIT PROVISIONS

404.1908 Crediting foreign periods of coverage.
404.1910 Person qualifies under more than one totalization agreement.
404.1911 Effects of a totalization agreement on entitlement to hospital insurance benefits.

COVERAGE PROVISIONS

404.1913 Precluding dual coverage.
404.1914 Certificate of coverage.
404.1915 Payment of contributions.

COMPUTATION PROVISIONS

404.1918 How benefits are computed.
404.1919 How benefits are recomputed.
404.1920 Supplementing the U.S. benefit if the total amount of the combined benefits is less than the U.S. minimum benefit.
404.1921 Benefits of less than $1 due.

OTHER PROVISIONS

404.1925 Applications.
404.1926 Evidence.
404.1927 Appeals.
404.1928 Effect of the alien non-payment provision.
404.1929 Overpayments.
404.1930 Disclosure of information.

Subpart U—Representative Payment

404.2001 Introduction.
404.2010 When payment will be made to a representative payee.
404.2015 Information considered in determining whether to make representative payments.
404.2020 Information considered in selecting a representative payee.
404.2021 Order of preference in selecting a representative payee.
404.2025 Information to be submitted by a representative payee.
404.2030 Advance notice of the determination to make representative payment.
404.2035 Responsibilities of a representative payee.
404.2040 Use of benefit payments.
404.2040a Compensation for qualified organizations serving as representative payees.
404.2041 Liability for misuse of benefit payments.
404.2045 Conservation and investment of benefit payments.
404.2050 When a new representative payee will be selected.
404.2055 When representative payment will be stopped.
404.2060 Transfer of accumulated benefit payments.
404.2065 Accounting for benefit payments.

Subpart V—Payments for Vocational Rehabilitation Services

GENERAL PROVISIONS

404.2101 General.
404.2102 Purpose and scope.
404.2103 Definitions.
404.2104 Participation by State VR agencies or alternate participants.
404.2106 Basic qualifications for alternate participants.

PAYMENT PROVISIONS

404.2108 Requirements for payment.
404.2109 Responsibility for making payment decisions.
404.2110 What we mean by ''SGA'' and by ''a continuous period of 9 months''.
404.2111 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.
404.2112 Payment for VR services in a case where an individual continues to receive disability payments based on participation in an approved VR program.
404.2113 Payment for VR services in a case of VR refusal.
404.2114 Services for which payment may be made.
404.2115 When services must have been provided.
404.2116 When claims for payment for VR services must be made (filing deadlines).
404.2117 What costs will be paid.

ADMINISTRATIVE PROVISIONS

404.2118 Applicability of these provisions to alternate participants.
404.2119 Method of payment.
404.2120 Audits.
404.2121 Validation reviews.
404.2122 Confidentiality of information and records.
404.2123 Other Federal laws and regulations.
404.2127 Resolution of disputes.

Subpart A—Introduction, General Provisions and Definitions

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

§404.1 Introduction.

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

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

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

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

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

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

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

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

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

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

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

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

(l) Subpart L is reserved.

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

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

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

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

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

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

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

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

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

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

[26 FR 7054, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 27 FR 4513, May 11, 1962; 28 FR 14492, Dec. 31, 1963; 51 FR 11718, Apr. 7, 1986; 62 FR 38450, July 18, 1997]

§404.2 General definitions and use of terms.

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

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

(b) *Commissioner; Appeals Council; Administrative Law Judge defined.* (1) *Commissioner* means the Commissioner of Social Security.

(2) *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.

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

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

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

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

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

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

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

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

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

[26 FR 7055, Aug. 5, 1961; 26 FR 7760, Aug. 19, 1961, as amended at 28 FR 1037, Feb. 2, 1963; 28 FR 14492, Dec. 31, 1963; 29 FR 15509, Nov. 19, 1964; 41 FR 32886, Aug. 6, 1976; 51 FR 11718, Apr. 7, 1986; 61 FR 41330, Aug. 8, 1996; 62 FR 38450, July 18, 1997]

§ 404.3 General provisions.

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

(b) *Periods of limitation ending on nonwork days.* Pursuant to the provisions of section 216(j) of the act, effective September 13, 1960, where any provision of title II, or any provision of another law of the United States (other than the Internal Revenue Code of 1954) relating to or changing the effect of title II, or any regulation of the Commissioner issued under title II, provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this title or is necessary to establish or protect any rights under this title, and such period ends on a Saturday, Sunday or Federal legal holiday or on any other day all or

part of which is declared to be a nonwork day for Federal employees by statute or Executive Order, then such act shall be considered as done within such period if it is done on the first day thereafter which is not a Saturday, Sunday, or legal holiday or any other day all or part of which is declared to be a nonwork day for Federal employees either by statute or Executive Order. For purposes of this paragraph, the day on which a period ends shall include the final day of any extended period where such extension is authorized by law or by the Commissioner pursuant to law. Such extension of any period of limitation does not apply to periods during which benefits may be paid for months prior to the month an application for such benefits is filed pursuant to § 404.621, or to periods during which an application for benefits may be accepted as such pursuant to § 404.620.

[26 FR 7055, Aug. 5, 1961, as amended at 29 FR 15509, Nov. 19, 1964; 51 FR 11718, Apr. 7, 1986; 61 FR 41330, Aug. 8, 1996; 62 FR 38450, July 18, 1997]

Subpart B—Insured Status and Quarters of Coverage

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

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

GENERAL

§ 404.101 Introduction.

(a) *Insured status.* This subpart explains what we mean when we say that a person has insured status under the social security program. It also describes how a person may become fully insured, currently insured or insured for disability benefits. Your insured status is a basic factor in determining if you are entitled to old-age or disability insurance benefits or to a period of disability. It is also a basic factor in determining if dependents' or survivors' insurance benefits or a lump-sum death payment are payable based on your earnings record. If you are neither fully nor currently insured, no benefits are payable based on your earnings. (Subpart D of this part describes these benefits and the kind of insured status required for each.) In §§ 404.110 through 404.120 we tell how we determine if you are fully or currently insured. The rules for determining if you are insured for purposes of establishing a period of disability or becoming entitled to disability insurance benefits are in §§ 404.130 through 404.133. Whether you have the required insured status depends on the number of quarters of coverage (QCs) you have acquired.

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

§ 404.102 Definitions.

For the purpose of this subpart—

Act means the Social Security Act, as amended.

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

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

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

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

FULLY INSURED STATUS

§ 404.110 How we determine fully insured status.

(a) *General.* We describe how we determine the number of quarters of coverage (QCs) you need to be fully insured in paragraphs (b), (c), and (d) of this section. The table in § 404.115 may be used to determine the number of QCs you need to be fully insured under paragraph (b) of this section. We consider certain World War II veterans to

have died fully insured (see § 404.111). We also consider certain employees of private nonprofit organizations to be fully insured if they meet special requirements (see § 404.112).

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

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

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

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

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

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

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

(i) The year you die; or

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

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

(d) *How we credit QCs for fully insured status based on your total wages before 1951*—(1) *General.* For purposes of paragraph (b) of this section, we may use the following rules in crediting QCs based on your wages before 1951 instead of the rule in § 404.141(b)(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[50 FR 36573, Sept. 9, 1985]

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

(a) *General.* You may use the following table to determine the number of quarters of coverage (QCs) you need to be fully insured under § 404.110. Paragraphs (b) and (c) of this section tell you how to use this table.

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

Worker who reaches retirement age as described in § 404.110(b)(2)			Worker who dies before reaching retirement age as described in § 404.110(b)(2)		
Col. I—Date of birth	Col. II [1]		Col. III [2]—Year of death	Col. IV [3]	Col. V [4]—Age in year of death
	Men	Women			
Jan. 2, 1921 to Jan. 1, 1922	32	32	1986	35	57
Jan. 2, 1922 to Jan. 1, 1923	33	33	1987	36	58
Jan. 2, 1923 to Jan. 1, 1924	34	34	1988	37	59
Jan. 2, 1924 to Jan. 1, 1925	35	35	1989	38	60
Jan. 2, 1925 to Jan. 1, 1926	36	36	1990	39	61
Jan. 2, 1926 to Jan. 1, 1927	37	37	[7] 1991	40	62
Jan. 2, 1927 to Jan. 1, 1928	38	38	.....	.....	.....
Jan. 2, 1928 to Jan. 1, 1929	39	39	.....	.....	.....
Jan. 2, 1929 or later	40	.....	.....	.....	

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

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

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

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

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

CURRENTLY INSURED STATUS

§ 404.120 How we determine currently insured status.

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

(1) Die;

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

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

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

DISABILITY INSURED STATUS

§ 404.130 How we determine disability insured status.

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

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

(1) You are fully insured; and

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

(c) *Rule II—You become disabled before age 31.* You are insured in a quarter for

purposes of establishing a period of disability or becoming entitled to disability insurance benefits if in that quarter—

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

(2) You are fully insured; and

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

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

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

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

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

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

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

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

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

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

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

(2) You are fully insured.

(f) *How we determine the 40-quarter or other period.* In determining the 40-quarter period or other period in paragraph (b), (c), or (d) of this section, we do not count any quarter all or part of which is in a prior period of disability established for you, unless the quarter is the first or last quarter of this period and the quarter is a QC. However, we will count all the quarters in the prior period of disability established for you if by doing so you would be entitled to benefits or the amount of the benefit would be larger.

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

§ 404.131 When you must have disability insured status.

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

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

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

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

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

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

In determining if you are fully insured for purposes of paragraph (b), (c), (d), or (e) of § 404.130 on disability insured status, we use the fully insured

status requirements in § 404.110, but apply the following rules in determining when the period of elasped years ends:

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

(1) The year you become age 62; or

(2) The year in which—

(i) Your period of disability begins;

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

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

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

(1) The year 1975; or

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

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

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

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

QUARTERS OF COVERAGE

§ 404.140 What is a quarter of coverage.

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

(b) *How we credit QCs based on earnings before 1978 (General).* Before 1978, wages were generally reported on a quarterly basis and self-employment income was reported on an annual basis. For the most part, we credit QCs for calendar years before 1978 based on your quarterly earnings. For these years, as explained in § 404.141, we generally credit you with a QC for each calendar quarter in which you were paid at least $50 in wages or were credited with at least $100 of self-employment income. Section 404.142 tells how self-employment income derived in a taxable year beginning before 1978 is credited to specific calendar quarters for purposes of § 404.141.

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

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

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

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

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

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

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

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

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

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

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

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

(2) If you derived self-employment income (or derived self-employment income and also were paid wages) during a taxable year beginning after 1950 and before 1978 at least equal to the self-employment income and wage limitation in effect for that year as described in § 404.1068(b), we credit you with a QC for each calendar quarter wholly or partly in that taxable year.

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

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

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

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

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

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

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

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

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

credit you with more than four QCs for any calendar year. The amount of wages and self-employment income that you must have for each QC is—

(1) $250 for calendar year 1978; and

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

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

(1) Give you fully or currently insured status;

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

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

[45 FR 25834, Apr. 15, 1980, as amended at 62 FR 38450, July 18, 1997]

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

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

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

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

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

§ 404.145 When you acquire a quarter of coverage.

If we credit you with a quarter of coverage (QC) for a calendar quarter under paragraph (b), (c), or (d) of § 404.141 for calendar years before 1978 or assign it to a specific calendar quarter under paragraph (b) of § 404.143 for calendar years after 1977, you acquire the QC as of the first day of the calendar quarter.

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

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

(a) A calendar quarter that has not begun;

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

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

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

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

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

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

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

Calendar year	Amount needed
1979	$260
1980	290
1981	310
1982	340
1983	370
1984	390
1985	410
1986	440
1987	460
1988	470

Calendar year	Amount needed
1989	500
1990	520
1991	540
1992	570

[45 FR 25384, Apr. 15, 1980, as amended at 52 FR 8247, Mar. 17, 1987; 57 FR 44096, Sept 24, 1992; 62 FR 38450, July 18, 1997]

Subpart C—Computing Primary Insurance Amounts

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

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

GENERAL

§ 404.201 Introduction.

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

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

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

(c) In §§ 404.230 through 404.233, we describe the guaranteed alternative method of computing primary insurance amounts that applies to people who reach age 62 after 1978 but before 1984;

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

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

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

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

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

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

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

§ 404.202 Other regulations related to this subpart.

This subpart is related to several others. In subpart B of this part, we describe how you become insured for social security benefits as a result of your work in covered employment. In subpart D, we discuss the different kinds of social security benefits available—old-age and disability benefits for you and benefits for your dependents and survivors—the amount of the benefits, and the requirements you and your family must meet to qualify for

them; your work status, your age, the size of your family, and other factors may affect the amount of the benefits for you and your family. Rules relating to deductions, reductions, and nonpayment of benefits we describe in subpart E. In subpart F of this part, we describe what we do when a recalculation or recomputation of your primary insurance amount (as described in this subpart) results in our finding that you and your family have been overpaid or underpaid. In subparts G and H of this part, we tell how to apply for benefits and what evidence is needed to establish entitlement to them. In subpart J of this part, we describe how benefits are paid. Then in subparts I, K, N, and O of this part, we discuss your earnings that are taxable and creditable for social security purposes (and how we keep records of them), and deemed military wage credits which may be used in finding your primary insurance amount.

§ 404.203 Definitions.

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

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

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

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

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

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

[47 FR 30734, July 15, 1982, as amended at 62 FR 38450, July 18, 1997]

§ 404.204 Methods of computing primary insurance amounts—general.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 404.210 Average-indexed-monthly-earnings method.

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

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

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

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

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

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

§ 404.211 Computing your average indexed monthly earnings.

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

(b) *Which earnings may be used in computing your average indexed monthly earnings*—(1) *Earnings.* In computing your average indexed monthly earnings, we use wages, compensation, self-employment income, and deemed military wage credits (see §§ 404.1340 through 404.1343) that are creditable to you for social security purposes for years after 1950.

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

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

(1) For the years 1951 through 1977, four times the amount of average taxable wages that were reported to the

Social Security Administration for the first calendar quarter of each year for social security tax purposes. For years prior to 1973, these average wages were determined from a sampling of these reports.

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

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

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

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

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

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

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

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

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

Step 1. The first step in indexing Ms. A's earnings is to find the relationship between the general wage level in Ms. A's indexing year (1977) and the general wage level in each of the years 1951–1976. We refer to appendix I

for average wage figures, and perform the following computations:

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

Step 2. After we have found these indexing quotients, we multiply Ms. A's actual year-by-year earnings by them to find her indexed earnings, as shown below:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) We will publish benefit formulas for years after 1979 in the FEDERAL REGISTER at the same time we publish the average of the total wage figures. We begin to use a new benefit formula as soon as it is applicable, even before we periodically update appendix II.

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

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

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

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

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

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

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

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

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

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

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

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

(3) For the same months after 1985 that you are entitled to old-age or disability benefits, you are also entitled to a monthly pension(s) for which you first became eligible after 1985 based in whole or part on your earnings in employment which was not covered under Social Security. We consider you to first become eligible for a monthly pension in the first month for which you met all requirements for the pension except that you were working or had not yet applied. In determining whether you are eligible for a pension before 1986, we consider all applicable service used by the pension-paying agency. (Noncovered employment includes employment outside the United States which is not covered under the United States Social Security system. Pensions from noncovered employment outside the United States include both pensions from social insurance systems that base benefits on earnings but not on residence or citizenship, and those from private employers. However, for benefits payable for months prior to January 1995, we will not modify the computation of a totalization benefit (see §§ 404.1908 and 404.1918) as a result of your entitlement to another pension based on employment covered by a totalization agreement. Beginning January 1995, we will not modify the computation of a totalization benefit in any case (see § 404.213(e)(8)).

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

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

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

(3) If the monthly pension amount which we will use in computing your

primary insurance amount is not a multiple of $0.10, we will round it to the next lower multiple of $0.10.

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

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

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

(ii) 70 percent for initial eligibility in 1987;

(iii) 60 percent for initial eligibility in 1988;

(iv) 50 percent for initial eligibility in 1989;

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

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

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

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

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

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

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

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

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

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

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

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

the Social Security Amendments of 1983.

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

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

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

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

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

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

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

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

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

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

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

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

AVERAGE-MONTHLY-WAGE METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.220 Average-monthly-wage method.

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

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

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

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

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

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

§ 404.221 Computing your average monthly wage.

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

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

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

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

(1) We count the years beginning with 1951 or (if later) the year you reached age 22 and ending with the year before you reached age 62, or became disabled, or died before age 62. Any part of a year—or years—in which you were disabled, as defined in § 404.1505, is not counted unless doing so would give you a higher average monthly wage. In that case, we count all the years during the period of disability, even if you had no earnings in some of those years. These are your *elapsed years.* (If you are a male and you reached age 62 before 1975, see paragraph (c)(2) of this section for the rules on finding your elapsed years.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) *Finding your primary insurance amount from benefit table.* We find your average monthly wage in column III of the table. Your primary insurance amount appears on the same line in column IV (column II if you are entitled to benefits for any of the 12 months preceding the effective month in column IV). As explained in § 404.212(e), there is a minimum primary insurance amount of $122 payable for persons who became eligible or died after 1978 and before January 1982. There is also an alternative minimum of $121.80 (before the application of cost-of-living increases) for members of this group whose benefits were computed from the benefit table in effect in December 1978 on the basis of either the old-start computation method in §§ 404.240 through 404.242 or the guaranteed alternative computation method explained in §§ 404.230 through 404.233. However, as can be seen from the extended table in appendix III, the lowest primary insurance amount under this method is now $1.70 for individuals for whom the minimum benefit has been repealed.

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

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

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

§ 404.230 Guaranteed alternative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Year	Earnings
1951	$3,600
1952	3,600
1953	3,600
1954	3,600
1955	4,200
1956	4,200
1957	4,200
1958	4,200
1959	4,800
1960	4,800
1961	4,800
1962	4,800
1963	4,800
1964	4,800
1965	4,800

Year	Earnings
1966	6,600
1967	6,600
1968	7,800
1969	7,800
1970	7,800
1971	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700

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

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

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

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

OLD-START METHOD OF COMPUTING PRIMARY INSURANCE AMOUNTS

§ 404.240 Old-start method—general.

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

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

§ 404.241 1977 simplified old-start method.

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

(1) You must—

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

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

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

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

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

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

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

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

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

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

(3) Next, we apply the old-start formula to your average monthly wage, as

described in paragraph (e)(1) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Example: From the example in paragraph (c)(2) of this section, we see that Ms. D's elapsed years total 40 (number of years at ages 22 to 61, both inclusive). Her benefit computation years, therefore, must total 35. Since she has only 16 years of actual earnings, we must include 19 years of zero earnings in this old-start computation to reach the required 35 benefit computation years.

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

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

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

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

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

If your primary insurance amount as computed under the old-start method is higher than your primary insurance amount computed under the average-

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

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

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

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

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

[52 FR 47918, Dec. 17, 1987]

SPECIAL COMPUTATION RULES FOR PEOPLE WHO HAD A PERIOD OF DISABILITY

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

If you were disabled at some time in your life, received disability insurance benefits, and those benefits were terminated because you recovered from your disability or because you engaged in substantial gainful activity, special rules apply in computing your primary insurance amount when you become eligible after 1978 for old-age insurance benefits or if you become re-entitled to disability insurance benefits or die. (For purposes of §§ 404.250 through 404.252, we use the term *second entitlement* to refer to this situation.) There are two sets of rules:

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

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

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

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

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

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

(3) The primary insurance amount computed for you as of the time of

your second entitlement under any method for which you are qualified at that time, including the average-indexed-monthly-earnings method if the previous period of disability is disregarded.

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

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

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

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

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

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

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

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

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

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

SPECIAL MINIMUM PRIMARY INSURANCE AMOUNTS

§ 404.260 Special minimum primary insurance amounts.

Regardless of the method we use to compute your primary insurance amount, if the special minimum primary insurance amount described in § 404.261 is higher, then your benefits (and those of your dependents or survivors) will be based on the special minimum primary insurance amount. Special minimum primary insurance amounts are not based on a worker's average earnings, as are primary insurance amounts computed under other methods. Rather, the special minimum primary insurance amount is designed to provide higher benefits to people who worked for long periods in low-paid jobs covered by social security.

§ 404.261 Computing your special minimum primary insurance amount.

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

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

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

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

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

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

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

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

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

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

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

COST-OF-LIVING INCREASES

§ 404.270 Cost-of-living increases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) *Which index we use.* We use the CPI if the OASDI fund ratio is 15.0 percent or more for any year from 1984 through 1988, and if the ratio is 20.0 percent or more for any year after 1988. We use either the CPI or the AWI, depending on which has the lower percentage increase in the applicable measuring period (see § 404.274), if the OASDI fund ratio is less than 15.0 percent for any year from 1984 through 1988, and if the ratio is less than 20.0 percent for any year after 1988. For example, if the OASDI fund ratio for a year is 17.0 percent, the cost-of-living increase effective December of that year will be based on the CPI.

[51 FR 12603, Apr. 14, 1986]

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

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

[51 FR 12603, Apr. 14, 1986]

§ 404.274 Measuring the increase in the indexes.

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

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

(1) Begins with—

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

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

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

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

(1) Begins with—

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

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

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

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

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

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

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

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

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

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

[51 FR 12603, Apr. 21, 1986]

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

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

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

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

[51 FR 12604, Apr. 21, 1986]

§ 404.276 Publication of notice of increase.

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

(a) The fact that an increase is due;

(b) The amount of the increase;

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

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

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

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

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

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

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

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

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

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

(ii) Beginning with June of the earlier of—

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

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

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

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

§ 404.278 Additional cost-of-living increase.

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

(1) The OASDI fund ratio is more than 32.0 percent in the given year in

which a cost-of-living increase is due; and

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

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

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

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

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

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

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

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

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

(3) Subtract 1 from the last product;

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

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

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

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

(2) Add 100 to the actual CPBI;

(3) Divide the answer from paragraph (e)(1) of this section by the answer from paragraph (e)(2) of this section, multiply the quotient by 100, and round to the nearest 0.1. The result is the additional increase percentage, which we apply to the appropriate amount described in § 404.271 after that amount has been increased under § 404.275 for a given year. If that increased amount is not a multiple of $0.10, we will decrease it to the next lower multiple of $0.10.

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

[51 FR 12604, Apr. 21, 1986]

RECOMPUTING YOUR PRIMARY INSURANCE AMOUNT

§ 404.280 Recomputations.

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

we do most recomputations automatically. In the following sections, we explain:

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

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

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

(d) Automatic recomputations (§ 404.285),

(e) Requesting a recomputation (§ 404.286),

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

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

[52 FR 47918, Dec. 17, 1987]

§ 404.281 Why your primary insurance amount may be recomputed.

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

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

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

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

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

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

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

§ 404.282 Effective date of recomputations.

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

first month you are entitled to the pension. Finally, if your primary insurance amount was affected by your entitlement to a pension, we will recompute the amount to disregard the pension, effective with the month of your death.

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

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

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

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

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

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

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

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

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

Example 1. Ms. A, whose primary insurance amount we computed to be $432.40 in June 1979 in §§ 404.210 through 404.212 (based on average indexed monthly earnings of $903), had earnings of $11,000 in 1979 which were not used in the initial computation of her primary insurance amount. We may recompute her primary insurance amount effective for January 1980. In this recomputation, her 1979 earnings may be substituted in their actual dollar amount for the lowest year of her indexed earnings that was used in the initial computation. In Ms. A's case, we substitute the $11,000 for her 1966 indexed earnings of $8,911.36. Her total indexed earnings are now $251,470.05 and her new average indexed monthly earnings are $911. We apply to Ms. A's new average indexed monthly earnings the same benefit formula we used in the initial computation. Doing so produces an amount of $396.00. An automatic cost-of-living increase of 9.9 percent was effective in June 1979. We increase the $396.00 amount by 9.9 percent to find Ms. A's recomputed primary insurance amount of $435.30. Later we increased the primary insurance amount to $497.60 to reflect the 14.3 percent cost-of-living increase beginning June 1980 and to $553.40 to reflect the 11.2 percent cost-of-living increase beginning June 1981.

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

We next find Mr. B's new average monthly wage in column III of the December 1978 benefit table in appendix III. Reading across, we find his recomputed primary insurance amount on the same line in column IV,

which is $407.70. We then apply the 9.9 percent, the 14.3 percent and the 11.2 percent automatic cost-of-living increases for June 1979, June 1980, and June 1981, respectively, to compute Mr. B's primary insurance amount of $569.60.

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

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

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

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

§ 404.285 Recomputations performed automatically.

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

§ 404.286 How to request an immediate recomputation.

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

§ 404.287 Waiver of recomputation.

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

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

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

(b) *Already entitled to benefits and to a pension based on noncovered employment.*

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

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

[52 FR 47918, Dec. 17, 1987]

RECALCULATIONS OF PRIMARY INSURANCE AMOUNTS

§ 404.290 Recalculations.

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

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

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

(3) Correction of clerical or mathematical errors; or

(4) Other miscellaneous changes in status.

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

APPENDICES TO SUBPART C

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

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

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

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

[52 FR 8247, Mar. 17, 1987]

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

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

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

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

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

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

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

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

BENEFIT FORMULAS

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

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

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

APPENDIX III TO SUBPART C OF PART 404—BENEFIT TABLE

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

The benefit table in effect in December 1978 had a minimum primary insurance amount of $121.80. As explained in §404.222(b), certain workers eligible, or who died without having been eligible, before 1982 had their benefit computed from this table. However, the minimum benefit provision was repealed for other workers by the 1981 amendments to the Act (the Omnibus Budget Reconciliation Act of 1981, Pub. L. 97–35 as modified by Pub. L. 97–123). As a result, this benefit table includes a downward extension from the former minimum of $121.80 to the lowest primary insurance amount now possible. The

extension is calculated as follows. For each single dollar of average monthly wage in the benefit table, the primary insurance amount shown for December 1978 is $121.80 multiplied by the ratio of that average monthly wage to $76. The upper limit of each primary insurance benefit range in column I of the table is $16.20 multiplied by the ratio of the average monthly wage in column III of the table to $76. The maximum family benefit is 150 percent of the corresponding primary insurance amount.

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

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

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
				1	1.70	2.60
	0.42		2	2	3.30	5.00
0.43	.63		3	3	4.90	7.40
.64	.85		4	4	6.50	9.80
.86	1.06		5	5	8.10	12.20
1.07	1.27		6	6	9.70	14.60
1.28	1.49		7	7	11.30	17.00
1.50	1.70		8	8	12.90	19.40
1.71	1.91		9	9	14.50	21.80
1.92	2.13		10	10	16.10	24.20
2.14	2.34		11	11	17.70	26.60
2.35	2.55		12	12	19.30	29.00
2.56	2.77		13	13	20.90	31.40
2.78	2.98		14	14	22.50	33.80
2.99	3.19		15	15	24.10	36.20
3.20	3.41		16	16	25.70	38.60
3.42	3.62		17	17	27.30	41.00
3.63	3.83		18	18	28.90	43.40
3.84	4.05		19	19	30.50	45.80
4.06	4.26		20	20	32.10	48.20
4.27	4.47		21	21	33.70	50.60
4.48	4.68		22	22	35.30	53.00
4.69	4.90		23	23	36.90	55.40
4.91	5.11		24	24	38.50	57.80
5.12	5.32		25	25	40.10	60.20
5.33	5.54		26	26	41.70	62.60
5.55	5.75		27	27	43.30	65.00
5.76	5.96		28	28	44.90	67.40
5.97	6.18		29	29	46.50	69.80
6.19	6.39		30	30	48.10	72.20
6.40	6.60		31	31	49.70	74.60
6.61	6.82		32	32	51.30	77.00
6.83	7.03		33	33	52.90	79.40
7.04	7.24		34	34	54.50	81.80
7.25	7.46		35	35	56.10	84.20
7.47	7.67		36	36	57.70	86.60
7.68	7.88		37	37	59.30	89.00
7.89	8.10		38	38	60.90	91.40
8.11	8.31		39	39	62.60	93.90

EXTENDED DECEMBER 1978 TABLE OF BENEFITS EFFECTIVE JANUARY 1982—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective January 1982: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
8.32	8.52		40	40	64.20	96.30
8.53	8.73		41	41	65.80	98.70
8.74	8.95		42	42	67.40	101.10
8.96	9.16		43	43	69.00	103.50
9.17	9.37		44	44	70.60	105.90
9.38	9.59		45	45	72.20	108.30
9.60	9.80		46	46	73.80	110.70
9.81	10.01		47	47	75.40	113.10
10.02	10.23		48	48	77.00	115.50
10.24	10.44		49	49	78.60	117.90
10.45	10.65		50	50	80.20	120.30
10.66	10.87		51	51	81.80	122.70
10.88	11.08		52	52	83.40	125.10
11.09	11.29		53	53	85.00	127.50
11.30	11.51		54	54	86.60	129.90
11.52	11.72		55	55	88.20	132.30
11.73	11.93		56	56	89.80	134.70
11.94	12.15		57	57	91.40	137.10
12.16	12.36		58	58	93.00	139.50
12.37	12.57		59	59	94.60	141.90
12.58	12.78		60	60	96.20	144.30
12.79	13.00		61	61	97.80	146.70
13.01	13.21		62	62	99.40	149.10
13.22	13.42		63	63	101.00	151.50
13.43	13.64		64	64	102.60	153.90
13.65	13.85		65	65	104.20	156.30
13.86	14.06		66	66	105.80	158.70
14.07	14.28		67	67	107.40	161.10
14.29	14.49		68	68	109.00	163.50
14.50	14.70		69	69	110.60	165.90
14.71	14.92		70	70	112.20	168.30
14.93	15.13		71	71	113.80	170.70
15.14	15.34		72	72	115.40	173.10
15.35	15.56		73	73	117.00	175.50
15.57	15.77		74	74	118.60	177.90
15.78	15.98		75	75	120.20	180.30
15.99	16.20		76	76	121.80	182.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
	16.20	114.30		76	121.80	182.70
16.21	16.84	116.10	77	78	123.70	185.60
16.85	17.60	118.80	79	80	126.60	189.90
17.61	18.40	121.00	81	81	128.90	193.50
18.41	19.24	123.00	82	83	131.20	196.80
19.25	20.00	125.80	84	85	134.00	201.00
20.01	20.64	128.10	86	87	136.50	204.80
20.65	21.28	130.10	88	89	138.60	207.90
21.29	21.88	132.70	90	90	141.40	212.10
21.89	22.28	135.00	91	92	143.80	215.70
22.29	22.68	137.20	93	94	146.20	219.20

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
22.59	23.08	139.40	95	96	148.50	222.80
23.09	23.44	142.00	97	97	151.30	227.00
23.45	23.76	144.30	98	99	153.70	230.60
23.77	24.20	147.10	100	101	156.70	235.10
24.21	24.60	149.20	102	102	158.90	238.50
24.61	25.00	151.70	103	104	161.60	242.40
25.01	25.48	154.50	105	106	164.60	246.90
25.49	25.92	157.00	107	107	167.30	251.00
25.93	26.40	159.40	108	109	169.80	254.80
26.41	26.94	161.90	110	113	172.50	258.80
26.95	27.46	164.20	114	118	174.90	262.40
27.47	28.00	166.70	119	122	177.60	266.50
28.01	28.68	169.30	123	127	180.40	270.60
28.69	29.25	171.80	128	132	183.00	274.60
29.26	29.68	174.10	133	136	185.50	278.30
29.69	30.36	176.50	137	141	188.00	282.10
30.37	30.92	179.10	142	146	190.80	286.20
30.93	31.36	181.70	147	150	193.60	290.40
31.37	32.00	183.90	151	155	195.90	293.90
32.01	32.60	186.50	156	160	198.70	298.10
32.61	33.20	189.00	161	164	201.30	302.00
33.21	33.88	191.40	165	169	203.90	305.90
33.89	34.50	194.00	170	174	206.70	310.10
34.51	35.00	196.30	175	178	209.10	313.70
35.01	35.80	198.90	179	183	211.90	318.00
35.81	36.40	201.30	184	188	214.40	321.70
36.41	37.08	203.90	189	193	217.20	326.00
37.09	37.60	206.40	194	197	219.90	329.90
37.61	38.20	208.80	198	202	222.40	333.60
38.21	39.12	211.50	203	207	225.30	338.00
39.13	39.68	214.00	208	211	228.00	342.00
39.69	40.33	216.00	212	216	230.10	345.20
40.34	41.12	218.70	217	221	233.00	349.50
41.13	41.76	221.20	222	225	235.60	353.40
41.77	42.44	223.90	226	230	238.50	357.80
42.45	43.20	226.30	231	235	241.10	361.70
43.21	43.76	229.10	236	239	244.00	366.10
43.77	44.44	231.20	240	244	246.30	371.10
44.45	44.88	233.50	245	249	248.70	378.80
44.89	45.60	236.40	250	253	251.80	384.90
		238.70	254	258	254.30	392.50
		240.80	259	263	256.50	400.00
		243.70	264	267	259.60	206.00
		246.10	268	272	262.10	413.70
		248.70	273	277	264.90	421.20
		251.00	278	281	267.40	427.20
		253.50	282	286	270.00	434.90
		256.20	287	291	272.90	442.60
		258.30	292	295	275.10	448.50
		261.10	296	300	278.10	456.10
		263.50	301	305	280.70	463.80
		265.80	306	309	283.10	469.80
		268.50	310	314	286.00	477.40
		270.70	315	319	288.30	485.10
		273.20	320	323	291.00	491.10
		275.80	324	328	293.80	498.70
		278.10	329	333	296.20	506.20
		281.00	334	337	299.30	512.50
		283.00	338	342	301.40	519.90
		285.60	343	347	304.20	527.50
		288.30	348	351	307.10	533.60
		290.50	352	356	309.40	541.20
		293.30	357	361	312.40	548.80

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		295.60	362	365	314.90	554.90
		297.90	366	370	317.30	562.50
		300.60	371	375	320.20	569.90
		303.10	376	379	322.90	576.30
		305.70	380	384	325.60	583.90
		307.90	385	389	328.00	591.30
		310.30	390	393	330.50	597.40
		313.00	394	398	333.40	605.10
		315.40	399	403	336.00	612.70
		318.20	404	407	338.90	618.60
		320.20	408	412	341.10	626.30
		322.50	413	417	343.50	633.80
		324.80	418	421	346.00	639.90
		327.40	422	426	348.70	647.50
		329.60	427	431	351.10	655.10
		331.60	432	436	353.20	662.70
		334.40	437	440	356.20	665.70
		336.50	441	445	358.40	669.70
		338.70	446	450	360.80	673.40
		341.30	451	454	363.50	676.30
		343.50	455	459	365.90	680.10
		345.80	460	464	368.30	683.80
		347.90	465	468	370.60	687.10
		350.70	469	473	373.50	690.80
		352.60	474	478	375.60	694.60
		354.90	479	482	378.00	697.70
		357.40	483	487	380.70	701.60
		359.70	488	492	383.10	705.40
		361.90	493	496	385.50	708.40
		364.50	497	501	388.20	712.10
		366.60	502	506	390.50	715.80
		368.90	507	510	392.90	719.00
		371.10	511	515	395.30	722.80
		373.70	516	520	398.00	726.70
		375.80	521	524	400.30	729.50
		378.10	525	529	402.70	733.40
		380.80	530	534	405.60	737.10
		382.80	535	538	407.70	740.20
		385.10	539	543	410.20	744.10
		387.60	544	548	412.80	747.80
		389.90	549	553	415.30	751.60
		392.10	554	556	417.60	753.90
		393.90	557	560	419.60	756.90
		396.10	561	563	421.90	759.30
		398.20	564	567	424.10	762.30
		400.40	568	570	426.50	764.50
		402.30	571	574	428.50	767.50
		404.40	575	577	430.70	769.90
		406.20	578	581	432.70	772.80
		408.40	582	584	435.00	775.20
		410.20	585	588	436.90	778.20
		412.60	589	591	439.50	780.50
		414.60	592	595	441.60	783.50
		416.70	596	598	443.80	785.60
		418.70	599	602	446.00	788.90
		420.70	603	605	448.10	791.10
		422.80	606	609	450.30	794.00
		424.90	610	612	452.60	796.50
		426.90	613	616	454.70	799.50
		428.90	617	620	456.80	802.50
		431.00	621	623	459.10	804.80
		433.00	624	627	461.20	807.90
		435.10	628	630	463.40	810.70

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		437.10	631	634	465.60	814.70
		439.20	635	637	467.80	818.50
		441.40	638	641	470.10	822.40
		443.20	642	644	472.10	826.10
		445.40	645	648	474.40	830.10
		447.40	649	652	476.50	833.70
		448.60	653	656	477.80	836.10
		449.90	657	660	479.20	838.40
		451.50	661	665	480.90	841.50
		453.10	666	670	482.60	844.50
		454.80	671	675	484.40	847.40
		456.40	676	680	486.10	850.50
		458.00	681	685	487.80	853.50
		459.80	686	690	489.70	856.40
		461.20	691	695	491.20	859.60
		462.80	696	700	492.90	862.60
		464.50	701	705	494.70	865.60
		466.10	706	710	496.40	868.60
		467.70	711	715	498.20	871.50
		469.40	716	720	500.00	874.60
		471.00	721	725	501.70	877.60
		472.60	726	730	503.40	880.70
		474.20	731	735	505.10	883.80
		475.90	736	740	506.90	886.70
		477.40	741	745	508.50	889.90
		478.90	746	750	510.10	892.70
		480.40	751	755	511.70	896.40
		481.80	756	760	513.20	897.80
		483.20	761	765	514.70	900.40
		484.50	766	770	516.00	903.00
		485.80	771	775	517.40	905.40
		487.20	776	780	518.90	907.90
		488.60	781	785	520.40	910.40
		489.80	786	790	521.70	912.90
		491.10	791	795	523.10	915.40
		492.50	796	800	524.60	918.00
		494.00	801	805	526.20	920.50
		495.30	806	810	527.50	923.00
		496.70	811	815	529.00	925.60
		498.00	816	820	530.40	928.00
		499.40	821	825	531.90	930.60
		500.70	826	830	533.30	933.10
		502.00	831	835	534.70	935.70
		503.30	836	840	536.10	938.10
		504.70	841	845	537.60	940.80
		506.00	846	850	538.90	943.00
		507.50	851	855	540.50	945.70
		508.80	856	860	541.90	948.10
		510.20	861	865	543.40	950.70
		511.50	866	870	544.80	953.20
		512.90	871	875	546.30	955.70
		514.10	876	880	547.60	958.20
		515.50	881	885	549.10	960.80
		516.80	886	890	550.40	963.20
		518.20	891	895	551.90	966.00
		519.60	896	900	553.40	968.30
		521.00	901	905	554.90	970.90
		522.30	906	910	556.30	973.50
		523.70	911	915	557.80	976.00
		525.10	916	920	559.30	978.30
		526.30	921	925	560.60	961.00
		527.60	926	930	561.90	983.40
		529.00	931	935	563.40	985.90

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		530.40	936	940	564.90	988.50
		531.70	941	945	566.30	991.00
		533.00	946	950	567.70	993.50
		534.50	951	955	569.30	996.10
		535.90	956	960	570.80	998.60
		537.30	961	965	572.30	1,001.00
		538.40	966	970	573.40	1,003.60
		539.80	971	975	574.90	1,006.20
		541.20	976	980	576.40	1,008.50
		542.60	981	985	577.90	1,011.10
		543.80	986	990	579.20	1,013.60
		545.20	991	995	580.70	1,016.20
		546.60	996	1,000	582.20	1,018.60
		547.80	1,001	1,005	583.50	1,020.70
		548.90	1,006	1,010	584.60	1,023.20
		550.20	1,011	1,015	586.00	1,025.30
		551.50	1,016	1,020	587.40	1,027.80
		552.60	1,021	1,025	588.60	1,029.90
		553.80	1,026	1,030	589.80	1,032.20
		555.10	1,031	1,035	591.20	1,034.50
		556.20	1,036	1,040	592.40	1,036.70
		557.50	1,041	1,045	593.80	1,039.10
		558.80	1,046	1,050	595.20	1,041.30
		559.80	1,051	1,055	596.20	1,043.40
		561.10	1,056	1,060	597.60	1,045.90
		562.40	1,061	1,065	599.00	1,048.00
		563.60	1,066	1,070	600.30	1,050.50
		564.80	1,071	1,075	601.60	1,052.60
		566.00	1,076	1,080	602.80	1,054.90
		567.30	1,081	1,085	604.20	1,057.10
		568.40	1,086	1,090	605.40	1,059.40
		569.70	1,091	1,095	606.80	1,061.70
		571.00	1,096	1,100	608.20	1,064.00
		572.00	1,101	1,105	609.20	1,066.10
		573.30	1,106	1,110	610.60	1.068.50
		574.60	1,111	1,115	612.00	1,070.70
		575.70	1,116	1,120	613.20	1,073.10
		577.00	1,121	1,125	614.60	1,075.30
		578.20	1,126	1,130	615.80	1,077.60
		579.40	1,131	1,135	617.10	1,079.70
		580.60	1,136	1,140	618.40	1,082.20
		581.90	1,141	1,145	619.80	1,084.40
		583.10	1,146	1,150	621.10	1,086.70
		584.20	1,151	1,555	622.20	1,088.80
		585.50	1,156	1,160	623.60	1,091.10
		586.70	1,161	1,165	624.90	1,093.40
		587.90	1,166	1,170	626.20	1,095.80
		589.20	1,171	1,175	627.50	1,098.00
		590.30	1,176	1,180	628.70	1,100.20
		591.40	1,181	1,185	629.90	1,102.20
		592.60	1,186	1,190	631.20	1,104.30
		593.70	1,191	1,195	632.30	1,106.50
		594.80	1,196	1,200	633.50	1,108.60
		595.90	1,201	1,205	634.70	1,110.60
		597.10	1,206	1,210	636.00	1,112.90
		598.20	1,211	1,215	637.10	1,114.90
		599.30	1,216	1,220	638.30	1,117.00
		600.40	1,221	1,225	639.50	1,119.00
		601.60	1,226	1,230	640.80	1,121.20
		602.70	1,231	1,235	641.90	1,123.30
		603.80	1,236	1,240	643.10	1,125.40
		605.00	1,241	1,245	644.40	1,127.50
		606.10	1,246	1,250	645.50	1,129.60

TABLE OF BENEFITS IN EFFECT IN DECEMBER 1978—Continued

[In dollars]

I. Primary insurance benefit: If an individual's primary insurance benefit (as determined under § 404.241(e)) is—		II. Primary insurance amount effective June 1977: Or his or her primary insurance amount is—	III. Average monthly wage: Or his or her average monthly wage (as determined under § 404.221) is—		IV. Primary insurance amount effective June 1978: Then his or her primary insurance amount is—	V. Maximum family benefits: And the maximum amount of benefits payable on the basis of his or her wages and self-employment income is—
At least—	But not more than—		At least—	But not more than—		
		607.20	1,251	1,255	646.70	1,131.60
		608.30	1,256	1,260	647.90	1,133.80
		609.50	1,261	1,265	649.20	1,135.90
		610.60	1,266	1,270	650.30	1,138.00
		611.70	1,271	1,275	651.50	1,140.00
		612.80	1,276	1,280	652.70	1,142.20
		613.80	1,281	1,285	653.70	1,144.10
		614.80	1,286	1,290	654.90	1,146.10
		616.00	1,291	1,295	656.10	1,148.00
		617.00	1,296	1,300	657.20	1,150.00
		618.10	1,301	1,305	658.30	1,152.00
		619.10	1,306	1,310	659.40	1,154.00
		620.20	1,311	1,315	660.60	1,155.90
		621.30	1,316	1,320	661.70	1,157.90
		622.30	1,321	1,325	662.80	1,159.80
		623.40	1,326	1,330	664.00	1,161.90
		624.40	1,331	1,335	665.00	1,163.80
		625.50	1,336	1,340	666.20	1,165.80
		626.60	1,341	1,345	667.40	1,167.70
		627.60	1,346	1,350	668.40	1,169.70
		628.70	1,351	1,355	669.60	1,171.70
		629.70	1,356	1,360	670.70	1,173.70
		630.80	1,361	1,365	671.90	1,175.60
		631.80	1,366	1,370	672.90	1,177.70
		632.90	1,371	1,375	674.10	1,179.60
		633.90	1,376	1,380	675.20	1,181.60
		634.90	1,381	1,385	676.20	1,183.40
		635.90	1,386	1,390	677.30	1,185.30
		636.90	1,391	1,395	678.30	1,187.10
		637.90	1,396	1,400	679.40	1,189.00
		638.90	1,401	1,405	680.50	1,190.80
		639.90	1,406	1,410	681.50	1,192.70
		640.90	1,411	1,415	682.60	1,194.60
		641.90	1,416	1,420	683.70	1,196.50
		642.90	1,421	1,425	685.70	1,198.30
		643.90	1,426	1,430	684.80	1,200.20
		644.90	1,431	1,435	686.90	1,202.00
		645.90	1,436	1,440	687.90	1,203.90
		646.90	1,441	1,445	689.00	1,205.70
		647.90	1,446	1,450	690.10	1,207.70
		648.90	1,451	1,455	691.10	1,209.50
		649.90	1,456	1,460	692.20	1,211.40
		650.90	1,461	1,465	693.30	1,213.20
		651.90	1,466	1,470	694.30	1,215.10
		652.90	1,471	1,475	695.40	1,216.90

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

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

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

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

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

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

[57 FR 44096, Sept. 24, 1992]

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

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

JUNE 1979

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$12.70	$19.10
12	25.30	38.00
13	38.00	57.00
14	50.60	75.90
15	63.20	94.90
16	75.90	113.90
17	88.50	132.80
18	101.20	151.80
19	113.80	170.70
20	126.40	189.60
21	139.10	208.70
22	151.70	227.60
23	164.40	246.60
24	177.00	265.50
25	189.60	284.50
26	202.30	303.50
27	214.90	322.40
28	227.50	341.30
29	240.20	360.30
30	252.80	379.20

JUNE 1980

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

JUNE 1981

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefits
11	$16.30	$24.50
12	32.30	48.50
13	48.40	72.70
14	64.40	96.70
15	80.40	120.70
16	96.60	144.90
17	112.60	168.90
18	128.70	193.10
19	144.70	217.10
20	160.70	241.10
21	176.90	265.40
22	192.90	289.40
23	209.10	313.70
24	225.10	337.70
25	241.10	361.70

JUNE 1981—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefits
26	257.30	386.00
27	273.30	410.00
28	289.30	434.00
29	305.40	458.10
30	321.40	482.10

JUNE 1982

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

DECEMBER 1983

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

DECEMBER 1984

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$18.70	$28.10
12	37.00	55.60
13	55.50	83.50

DECEMBER 1984—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
14	74.00	111.10
15	92.40	138.70
16	111.00	166.60
17	129.40	194.10
18	148.00	222.00
19	166.40	249.60
20	184.70	277.20
21	203.30	305.20
22	221.80	332.80
23	240.40	360.80
24	258.80	388.30
25	277.20	415.90
26	295.90	444.00
27	314.30	471.60
28	332.70	499.20
29	351.10	526.90
30	369.50	554.50

DECEMBER 1985

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

DECEMBER 1986

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

DECEMBER 1986—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
29	366.60	550.20
30	385.80	579.00

DECEMBER 1987

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

DECEMBER 1988

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

DECEMBER 1989

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
11	$21.90	$33.00
12	43.60	65.70
13	65.60	98.70
14	87.40	131.30
15	109.30	164.00
16	131.20	197.20

DECEMBER 1989—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
17	153.10	229.90
18	175.00	262.70
19	196.90	295.50
20	218.60	328.20
21	240.80	361.30
22	262.50	394.00
23	284.60	427.30
24	306.40	460.00
25	328.20	492.50
26	350.30	525.90
27	372.20	558.60
28	393.90	591.20
29	415.70	624.20
30	437.60	656.80

DECEMBER 1990

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

DECEMBER 1991

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

DECEMBER 1991—Continued

I. Years of coverage	II. Primary insurance amount	III. Maximum family benefit
30	478.20	717.80

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

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

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

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

[57 FR 44097, Sept. 24, 1992]

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

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

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

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

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

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

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

GENERAL

§ 404.301 Introduction.

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

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

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

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

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

§ 404.302 Other regulations related to this subpart.

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

qualify for hospital and medical insurance if you are aged, disabled, or have chronic kidney disease.

§ 404.303 Definitions.

As used in this subpart:

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

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

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

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

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

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

We or *Us* means the Social Security Administration.

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

§ 404.304 General rules on benefit amounts.

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

(a) *Reductions based on age or earnings.* As explained in §§ 404.410 through 404.413, your old-age, wife's, husband's, widow's, or widower's benefits may be reduced if you choose to receive them before age 65. Also, as explained in §§ 404.415 through 404.417, deductions may be made from your benefits if your earnings or the insured person's earnings go over certain limits.

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

(c) [Reserved]

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

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

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

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

§ 404.305 When you may not be entitled to benefits.

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

(a) *Waiver of benefits.* If you have waived benefits and been granted a tax exemption on religious grounds as described in §§ 404.1039 and 404.1075, no one may become entitled to any benefits or

payments on your earnings record and you may not be entitled to benefits on anyone else's earnings record; and

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

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

OLD-AGE AND DISABILITY BENEFITS

§ 404.310 Who is entitled to old-age benefits.

You are entitled to old-age benefits if—

(a) You are at least 62 years old;

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

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

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

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

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

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

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

[48 FR 21926, May 16, 1983]

§ 404.312 Old-age benefit amounts.

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

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

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

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

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

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

(2) Retirement age is the age at which entitlement to full benefits may begin and is the age at which you may begin to earn delayed retirement credits. Age 65 is the retirement age for workers who reach that age before the year 2003. For workers who reach age 65

after 2002, retirement age will gradually increase from 65 to 67, depending on each person's date of birth.

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

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

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

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

Year you reach age 65	Delayed retirement credit percent
1990	7/24 of 1 percent.
1991	7/24 of 1 percent.
1992	1/3 of 1 percent.
1993	1/3 of 1 percent.
1994	3/8 of 1 percent.
1995	3/8 of 1 percent.
1996	5/12 of 1 percent.
1997	5/12 of 1 percent.
1998	11/24 of 1 percent.
1999	11/24 of 1 percent.
2000	1/2 of 1 percent.
2001	1/2 of 1 percent.
2002	13/24 of 1 percent.
2003	13/24 of 1 percent.
2004	7/12 of 1 percent.
2005	7/12 of 1 percent.
2006	5/8 of 1 percent.
2007	5/8 of 1 percent.
2008 and later	2/3 of 1 percent.

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

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

the following January. However, in either case, in the year in which you attain age 70 (72 before 1984), we compute the credit through the month before the month you reach that age and add it to your benefit amount beginning with that month.

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

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

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

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

[51 FR 12605, Apr. 14, 1986]

§ 404.315 Who is entitled to disability benefits.

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

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

(2) You apply;

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

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

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

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

§ 404.316 When entitlement to disability benefits begins and ends.

(a) You are entitled to disability benefits beginning with the first month covered by your application in which

you meet all the other requirements for entitlement. If a waiting period is required, your benefits cannot begin earlier than the first month following that period.

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

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

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

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

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

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

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

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

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

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

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

(i) You complete the program;

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

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

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

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

(e) If drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535, you may receive disability benefits on that basis for no more than 36 months regardless of the number of entitlement periods you may have. Not included in these 36 months are months in which treatment for your drug addiction or alcoholism

is not available, months before March 1995, and months for which your benefit payments were suspended for any reason. Benefits to your dependents may continue after the 36 months of benefits if, but for the operation of this paragraph, you would otherwise be entitled to benefits based on disability. The 36-month limit is no longer effective for benefits for months beginning after September 2004.

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

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

§ 404.317 Disability benefit amounts.

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

§ 404.320 Who is entitled to a period of disability.

(a) *General.* A period of disability is a continuous period of time during which you are disabled. If you become disabled, you may apply to have our records show how long your disability lasts. You may do this even if you do not qualify for disability benefits. If we establish a period of disability for you, the months in that period of time will not be counted in figuring your average earnings. If benefits payable on your earnings record would be denied or reduced because of a period of disability, the period of disability will not be taken into consideration.

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

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

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

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

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

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

§ 404.321 When a period of disability begins and ends.

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

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

the second month following the month in which your disability ended.

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

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

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

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

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

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

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

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

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

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

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

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

(b) You were mentally incompetent.

§ 404.325 The termination month.

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

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

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

[49 FR 22271, May 29, 1984]

BENEFITS FOR SPOUSES AND DIVORCED SPOUSES

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

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

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

(1) Your relationship to the insured as a wife or husband has lasted at least 1 year. (You will be considered to meet the 1-year duration requirement

throughout the month in which the first anniversary of the marriage occurs.)

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

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

(b) You apply;

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

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

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

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

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

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

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

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

(b) You apply;

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

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

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

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

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

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

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

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

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

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

(3) You are the divorced wife or divorced husband and you marry someone, other than the insured who is entitled to old-age benefits, unless that other person is someone entitled to benefits as a wife, husband, widow, widower, father, mother, parent or disabled child. Your benefits will end if

you remarry the insured who is not yet entitled to old-age benefits.

(4) If you are under age 62, there is no longer a child of the insured who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record. (See paragraph (c) of this section if you were entitled to wife's or husband's benefits for August 1981 on the basis of having a child in care.) (If you no longer have in your care a child who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record, your benefits may be subject to deductions as provided in § 404.421.)

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

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

(7) You die.

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

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

[44 FR 34481, June 15, 1979, as amended at 48 FR 21926, May 16, 1983; 49 FR 24115, June 12, 1984; 51 FR 11911, Apr. 8, 1986; 58 FR 64891, Dec. 10, 1993; 60 FR 8145, Feb. 10, 1995; 64 FR 14608, Mar. 26, 1999]

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

Your wife's or husband's monthly benefit is equal to one-half the insured person's primary insurance amount. If you are entitled as a divorced wife or as a divorced husband before the insured person becomes entitled, we will compute the primary insurance amount as if he or she became entitled to old-age benefits in the first month you are entitled as a divorced wife or as a divorced husband. The amount of your monthly benefit may change as explained in § 404.304.

[51 FR 11912, Apr. 8, 1986]

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

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

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

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

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

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

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

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

(3) You and the insured were the natural parents of a child; or you were married to the insured when either of

you adopted the other's child or when both of you adopted a child who was then under 18 years old.

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

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

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

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

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

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

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

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

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

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

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in paragraph (c)(3) of this section. The waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits the 5th month before your entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, the waiting period is not required;

(3) For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability does not have to have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits

under this provision for any month prior to January 1991; and

(4) You have not previously received 36 months of payments based on disability when drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), regardless of the number of entitlement periods you may have had, or your current application for widow(er)'s benefits is not based on a disability where drug addiction or alcoholism is a contributing factor material to the determination of disability.

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount; and

(e) You are unmarried, unless—

(1) You remarried after you became 60 years old; or

(2) For benefits for months after 1983—

(i) You are now age 60 or older;

(ii) You remarried after attaining age 50 but before attaining age 60; and

(iii) At the time of the remarriage, you were entitled to widow(er)'s benefits as a disabled widow(er); or

(3) For benefits for months after 1983—

(i) You are now at least age 50 but not yet age 60;

(ii) You remarried after attaining age 50; and

(iii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (i.e., your disability began within the specified time and before your remarriage).

[44 FR 34481, June 15, 1979, as amended at 47 FR 12162, Mar. 22, 1982; 49 FR 24115, June 12, 1984; 51 FR 4482, Feb. 5, 1986; 51 FR 10616, Mar. 28, 1986; 55 FR 25825, June 25, 1990; 57 FR 30119, July 8, 1992; 59 FR 14747, Mar. 30, 1994; 60 FR 8145, Feb. 10, 1995]

§ 404.336 Who is entitled to widow's or widower's benefits as a surviving divorced spouse.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Your disability continued during a waiting period of 5 full consecutive months, unless months beginning with the first month of eligibility for supplemental security income or federally administered State supplementary payments are counted, as explained in paragraph (c)(3) of this section. This waiting period may begin no earlier than the 17th month before you applied; the fifth month before the insured died; or if you were previously entitled to mother's, father's, widow's, or widower's benefits, the 5th month before your previous entitlement to benefits ended. If you were previously entitled to widow's or widower's benefits based upon a disability, the waiting period is not required; and

(3) For monthly benefits payable for months after December 1990, if you were or have been eligible for supplemental security income or a federally administered State supplementary payments, as specified in subparts B and T of part 416 of this chapter, respectively, your disability does not have to have continued through a separate, full 5-month waiting period before you may begin receiving benefits. We will include as months of the 5-month waiting period the months in a period beginning with the first month you received supplemental security income or a federally administered State supplementary payment and continuing through all succeeding months, regardless of whether the months in the period coincide with the months in which your waiting period would have occurred, or whether you continued to be eligible for supplemental security income or a federally administered State supplementary payment after the period began, or whether you met the nondisability requirements for entitlement to widow's or widower's benefits. However, we will not pay you benefits under this provision for any month prior to January 1991;

(d) You are not entitled to an old-age benefit that is equal to or larger than the insured person's primary insurance amount; and

(e) You are unmarried, unless for benefits for months after 1983—

(1) You remarried after you became 60 years old; or

(2)(i) You are now age 60 or older;

(ii) You remarried after attaining age 50 but before attaining age 60; and

(iii) At the time of the remarriage, you were entitled to widow(er)'s benefits as a disabled widow(er); or

(3)(i) You are now at least age 50 but not yet age 60;

(ii) You remarried after attaining age 50; and

(iii) You met the disability requirements in paragraph (c) of this section at the time of your remarriage (i.e., your disability began within the specified time and before your remarriage).

[44 FR 34481, June 15, 1979, as amended at 47 FR 12162, Mar. 22, 1982; 51 FR 4482, Feb. 5, 1986; 55 FR 25300, June 21, 1990; 55 FR 25825, June 25, 1990; 57 FR 30119, July 8, 1992; 58 FR 64891, Dec. 10, 1993]

§ 404.337 When widow's and widower's benefits begin and end.

(a) You are entitled to widow's or widower's benefits under § 404.335 or § 404.336 beginning with the first month covered by your application in which you meet all the other requirements for entitlement to such benefits.

(b) Your entitlement to benefits ends at the earliest of the following times:

(1) The month before the month in which you become entitled to an old-age benefit that is equal to or larger than the insured's primary insurance amount.

(2) If your widow's or widower's benefit is based upon a disability, the second month after the month your disability ends or, where disability ends on or after December 1, 1980, the month before your termination month (§ 404.325). However payments are subject to the provisions of paragraphs (c) and (d) of this section. You may remain eligible for payment of benefits if you became 65 years old before your termination month and you met the other requirements for widow's or widower's benefits. If your widow's or widower's benefit is based on a finding that drug addiction or alcoholism is a contributing factor material to the determination of disability as described in § 404.1535, your entitlement to benefits will terminate the month after the 12th consecutive month of suspension for noncompliance with treatment or after 36 months of benefits on that basis when treatment is available regardless

of the number of entitlement periods you may have had, unless you are otherwise disabled without regard to drug addiction or alcoholism.

(3) The month before the month in which you die.

(c)(1) Your benefits may be continued after your impairment is no longer disabling if—

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

(ii) You are participating in an appropriate program of vocational rehabilitation as described in § 404.316(c)(1)(ii);

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

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

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

(i) You complete the program;

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

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

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

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

[44 FR 34481, June 15, 1979, as amended at 47 FR 31542, July 21, 1982; 49 FR 22271, May 29, 1984; 51 FR 4482, Feb. 5, 1986; 51 FR 17617, May 14, 1986; 58 FR 64891, Dec. 10, 1993; 60 FR 8146, Feb. 10, 1995; 65 FR 16813, Mar. 30, 2000]

§ 404.338 Widow's and widower's benefits amounts.

Your widow's or widower's monthly benefit is equal to the insured person's primary insurance amount. If the insured person died before reaching age 62 and you are first eligible after 1984, we may compute a special primary insurance amount for the purpose of determining the amount of your monthly benefit (see § 404.212(b)). We may increase your monthly benefit amount if the insured person earned delayed retirement credit after age 65 by working or by delaying filing for benefits (see § 404.313). The amount of your monthly benefit may change as explained in § 404.304. In addition, your monthly benefit will be reduced if the insured person had been entitled to old-age benefits that were reduced for age because he or she chose to receive them before becoming 65 years old. In this instance, your benefit is reduced, if it would otherwise be higher, to either the amount the insured would have been entitled to if still alive or 82½ percent of his or her primary insurance amount, whichever is larger.

[44 FR 34481, June 15, 1979, as amended at 51 FR 4482, Feb. 5, 1986]

§ 404.339 Who is entitled to mother's or father's benefits.

You may be entitled as the widow or widower to mother's or father's benefits on the earnings record of someone who was fully or currently insured when he or she died. You are entitled to these benefits if—

(a) You are the widow or widower of the insured and meet the conditions described in § 404.335(a)(1);

(b) You apply for these benefits; or you were entitled to wife's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is entitled to child's benefits and he or she is under 16 years old or is disabled. Sections 404.348 and 404.349 describe when a child is *in your care*.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

§ 404.340 Who is entitled to mother's or father's benefits as a surviving divorced spouse.

You may be entitled to mother's or father's benefits as the suviving divorced wife or the surviving divorced husband of someone who was fully or currently insured when he or she died. You are entitled to these benefits if—

(a) You were validly married to the insured under State law as described in § 404.345 or you were deemed to be validly married as described in § 404.346 but the marriage ended in a final divorce and—

(1) You are the mother or father of the insured's child; or

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

(b) You apply for these benefits; or you were entitled to wife's or husband's benefits for the month before the insured died;

(c) You are unmarried;

(d) You are not entitled to widow's or widower's benefits, or to an old-age benefit that is equal to or larger than the full mother's or father's benefit; and

(e) You have *in your care* the insured's child who is under age 16 or disabled, is your natural or adopted child, and is entitled to child's benefits on the insured person's record. Sections 404.348 and 404.349 describe when a child is *in your care*.

[44 FR 34481, June 15, 1979, as amended at 45 FR 68932, Oct. 17, 1980; 48 FR 21927, May 16, 1983; 58 FR 64891, Dec. 10, 1993]

§ 404.341 When mother's and father's benefits begin and end.

(a) You are entitled to mother's or father's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

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

(1) You become entitled to a widow's or widower's benefit or to an old-age benefit that is equal to or larger than the full mother's or father's benefit.

(2) There is no longer a child of the insured who is under age 16 or disabled and entitled to a child's benefit on the insured's earnings record. (See paragraph (c) of this section if you were entitled to mother's or father's benefits for August 1981.) (If you no longer have in your care a child who is under age 16 or disabled and entitled to child's benefits on the insured's earnings record, your benefits may be subject to deductions as provided in § 404.421.)

(3) You remarry. Your benefits will not end, however, if you marry someone entitled to old-age, disability, wife's, husband's, widow's, widower's, father's, mother's, parent's or disabled child's benefits.

(4) You die.

(c) If you were entitled to spouse's benefits on the basis of having a child in care, or to mother's or father's benefits for August 1981, your entitlement will continue until September 1983, until the child reaches 18 (unless disabled) or is otherwise no longer entitled to child's benefits, or until one of the events described in paragraph (b)(1), (3), or (4) of this section occurs, whichever is earliest.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 49 FR 24115, June 12, 1984; 58 FR 64891, Dec. 10, 1993; 64 FR 14608, Mar. 26, 1999]

§ 404.342 Mother's and father's benefit amounts.

Your mother's or father's monthly benefit is equal to 75 percent of the insured person's primary insurance amount. The amount of your monthly benefit may change as explained in § 404.304.

§ 404.344 Your relationship by marriage to the insured.

You may be eligible for benefits if you are related to the insured person as a wife, husband, widow, or widower. To decide your relationship to the insured, we look first to State laws. The State laws that we use are discussed in § 404.345. If your relationship cannot be established under State law, you may still be eligible for benefits if your relationship as the insured's wife, husband, widow, or widower is based upon a *deemed valid marriage* as described in § 404.346.

§ 404.345 Your relationship as wife, husband, widow, or widower under State law.

To decide your relationship as the insured's wife or husband, we look to the laws of the State where the insured had a permanent home when you applied for wife's or husband's benefits. To decide your relationship as the insured's widow or widower, we look to the laws of the State where the insured had a permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa, we look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303. If you and the insured were validly married under State law at the time you apply for wife's or husband's benefits or at the time the insured died if you apply for widow's, widower's, mother's, or father's benefits, the relationship requirement will be met. The relationship requirement will also be met if under State law you would be able to inherit a wife's, husband's, widow's, or widower's share of the insured's personal property if he or she were to die without leaving a will.

§ 404.346 Your relationship as wife, husband, widow, or widower based upon a deemed valid marriage.

(a) *General.* If your relationship as the insured's wife, husband, widow, or widower cannot be established under State law as explained in § 404.345, you may be eligible for benefits based upon a deemed valid marriage. You will be deemed to be the wife, husband, widow, or widower of the insured if, in good faith, you went through a marriage ceremony with the insured that would have resulted in a valid marriage except for a legal impediment. A legal impediment includes only an impediment which results because a previous marriage had not ended at the time of the ceremony or because there was a defect in the procedure followed in connection with the intended marriage. For example, a defect in the procedure may be found where a marriage was performed through a religious ceremony in a country that requires a civil ceremony for a valid marriage. Good faith means that at the time of the ceremony you did not know that a legal impediment existed, or if you did know, you thought that it would not prevent a valid marriage.

(b) *Entitlement based upon a deemed valid marriage.* To be entitled to benefits as a wife, husband, widow or widower as the result of a deemed valid marriage, you and the insured must have been living in the same household (see § 404.347) at the time the insured died or, if the insured is living, at the time you apply for benefits. However, a marriage that had been deemed valid, shall continue to be deemed valid if the insured individual and the person entitled to benefits as the wife or husband of the insured individual are no longer living in the same household at the time of death of the insured individual.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21927, May 16, 1983; 58 FR 64892, Dec. 10, 1993]

§ 404.347 "Living in the same household" defined.

Living in the same household means that you and the insured customarily lived together as husband and wife in the same residence. You may be considered to be living in the same household although one of you is temporarily absent from the residence. An absence will be considered temporary if:

(a) It was due to service in the U.S. Armed Forces;

(b) It was 6 months or less and neither you nor the insured were outside of the United States during this time and the absence was due to business,

employment, or confinement in a hospital, nursing home, other medical institution, or a penal institution;

(c) It was for an extended separation, regardless of the duration, due to the confinement of either you or the insured in a hospital, nursing home, or other medical institution, if the evidence indicates that you were separated solely for medical reasons and you otherwise would have resided together; or

(d) It was based on other circumstances, and it is shown that you and the insured reasonably could have expected to live together in the near future.

[61 FR 41330, Aug. 8, 1996]

§ 404.348 When a child living with you is "in your care".

To become entitled to wife's benefits before you become 62 years old or to mother's or father's benefits, you must have the insured's child *in your care.* A child who has been living with you for at least 30 days is in your care unless—

(a) The child is in active military service;

(b) The child is 16 years old or older and not disabled;

(c) The child is 16 years old or older with a mental disability, but you do not actively supervise his or her activities and you do not make important decisions about his or her needs, either alone or with help from your spouse; or

(d) The child is 16 years old or older with a physical disability, but it is not necessary for you to perform personal services for him or her. Personal services are services such as dressing, feeding, and managing money that the child cannot do alone because of a disability.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

§ 404.349 When a child living apart from you is "in your care".

(a) *In your care.* A child living apart from you is in your care if—

(1) The child lived apart from you for not more than 6 months, or the child's current absence from you is not expected to last over 6 months;

(2) The child is under 16 years old, you supervise his or her activities and make important decisions about his or her needs, and one of the following circumstances exist:

(i) The child is living apart because of school but spends at least 30 days vacation with you each year unless some event makes having the vacation unreasonable; and if you and the child's other parent are separated, the school looks to you for decisions about the child's welfare;

(ii) The child is living apart because of your employment but you make regular and substantial contributions to his or her support; see § 404.366(a) for a definition of *contributions for support*;

(iii) The child is living apart because of a physical disability that the child has or that you have; or

(3) The child is 16 years old or older, is mentally disabled, and you supervise his or her activities, make important decisions about his or her needs, and help in his or her upbringing and development.

(b) *Not in your care.* A child living apart from you is not in your care if—

(1) The child is in active military service;

(2) The child is living with his or her other parent;

(3) The child is removed from your custody and control by a court order;

(4) The child is 16 years old or older, is mentally competent, and either has been living apart from you for 6 months or more or begins living apart from you and is expected to be away for more than 6 months;

(5) You gave your right to have custody and control of the child to someone else; or

(6) You are mentally disabled.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983]

CHILD'S BENEFITS

§ 404.350 Who is entitled to child's benefits.

(a) *General.* You are entitled to child's benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died if—

(1) You are the insured person's child, based upon a relationship described in §§ 404.355 through 404.359;

(2) You are dependent on the insured, as defined in §§ 404.360 through 404.365;

(3) You apply;

(4) You are unmarried; and

(5) You are under age 18; you are 18 years old or older and have a disability that began before you became 22 years old; or you are 18 years or older and qualify for benefits as a full-time student as described in § 404.367.

(b) *Entitlement preclusion for certain disabled children.* If you are a disabled child as referred to in paragraph (a)(5) of this section, and your disability was based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535) and your benefits ended after your receipt of 36 months of benefits, you will not be entitled to benefits based on disability for any month following such 36 months regardless of the number of entitlement periods you have had if, in such following months, drug addiction or alcoholism is a contributing factor material to the later determination of disability (as described in § 404.1535).

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 60 FR 8146, Feb. 10, 1995; 61 FR 38363, July 24, 1996]

§ 404.351 Who may be reentitled to child's benefits.

If your entitlement to child's benefits has ended, you may be reentitled on the same earnings record if you have not married and if you apply for reentitlement. Your reentitlement may begin with—

(a) The first month in which you qualify as a full-time student. (See § 404.367.)

(b) The first month in which you are disabled, if your disability began before you became 22 years old; or

(c) The first month you are under a disability that began before the end of the 84th month following the month in which your benefits had ended because an earlier disability had ended.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21927, May 16, 1983; 61 FR 38363, July 24, 1996]

§ 404.352 When child's benefits begin and end.

(a) *When benefits begin.* (1) If the insured is deceased, you are entitled to child's benefits beginning with the first month covered by your application in which you meet all other requirements for entitlement.

(2) If the insured is living, you are entitled to child's benefits beginning with the first month covered by your application:

(i) *Throughout* which you meet all the other requirements for entitlement if your first month of entitlement is September 1981 or later; or

(ii) *In* which you meet all the other requirements for entitlement if your first month of entitlement is before September 1981.

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

(1) You become 18 years old, unless you are disabled or a full-time student. If you become 18 years old and you are disabled, your entitlement to disability benefits ends with the second month following the month in which your disability ends. If your disability ends on or after December 1, 1980, your entitlement to disability benefits continues, subject to the provisions of paragraphs (c) and (d) of this section, until the month before your termination month (§ 404.325). If you become 18 years old and you qualify as a full-time student who is not disabled, your entitlement ends with the last month you are a full-time student or, if earlier, the month before the month you become age 19. If you become age 19 in a month in which you have not completed the requirements for, or received, a diploma or equivalent certificate from an elementary or secondary school, your entitlement will end with the month in which the quarter or semester in which you are enrolled ends if you are required to enroll for each quarter or semester. If the school you are attending does not have a quarter or semester system which requires reenrollment, your benefits will end with the month you complete the course or, if earlier, the first day of the third month following the month in which you become 19 years old.

(2) You marry. Your benefits will not end, however, if you are age 18 or older, disabled, and you marry a person entitled to child's benefits based on disability or person entitled to old-age, divorced wife's, divorced husband's,

widow's, widower's, mother's, father's, parent's, or disability benefits.

(3) The insured's entitlement to old-age or disability benefits ends for a reason other than death or the attainment of age 65. Exception: Your benefits will continue if the insured person was entitled to disability benefits based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of his or her disability (as described in § 404.1535), the insured person's benefits ended after 36 months of payment (see § 404.316(e)) or 12 consecutive months of suspension for noncompliance with treatment (see § 404.316(f)), and the insured person remains disabled.

(4) You die.

(c) If you are entitled to benefits as a disabled child age 18 or over and your disability is based on a finding that drug addiction or alcoholism was a contributing factor material to the determination of disability (as described in § 404.1535), your benefits also will terminate under the following conditions:

(1) If your benefits have been suspended for a period of 12 consecutive months for failure to comply with treatment, your benefits will terminate with the month following the 12 months unless you are otherwise disabled without regard to drug addiction or alcoholism (see § 404.470(c)).

(2) If you have received 36 months of benefits on that basis when treatment is available, regardless of the number of entitlement periods you may have had, your benefits will terminate with the month following such 36-month payment period unless you are otherwise disabled without regard to drug addiction or alcoholism.

(d)(1) Your benefits may be continued after your impairment is no longer disabling if—

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

(ii) You are participating in an appropriate program of vocational rehabilitation as described in § 404.316(c)(1)(ii);

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

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

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

(i) You complete the program;

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

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

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

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

[44 FR 34481, June 15, 1979, as amended at 47 FR 31543, July 21, 1982; 48 FR 21927, May 16, 1983; 49 FR 22271, May 29, 1984; 49 FR 24115, June 12, 1984; 51 FR 17617, May 14, 1987; 60 FR 8146, Feb. 10, 1995; 61 FR 38363, July 24, 1996]

§ 404.353 Child's benefit amounts.

(a) *General.* Your child's monthly benefit is equal to one-half of the insured person's primary insurance amount if he or she is alive and three-fourths of the primary insurance amount if he or she has died. The

amount of your monthly benefit may change as explained in § 404.304.

(b) *Entitlement to more than one benefit.* If you are entitled to a child's benefit on more than one person's earnings record, you will ordinarily receive only the benefit payable on the record with the highest primary insurance amount. If your benefit before any reduction would be larger on an earnings record with a lower primary insurance amount and no other person entitled to benefits on any earnings record would receive a smaller benefit as a result of your receiving benefits on the record with the lower primary insurance amount, you will receive benefits on that record. See § 404.407(d) for a further explanation. If you are entitled to a child's benefit and to other dependent's or survivor's benefits, you can receive only the highest of the benefits.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 48 FR 21928, May 16, 1983; 51 FR 12606, Apr. 14, 1986; 61 FR 38363, July 24, 1996]

§ 404.354 Your relationship to the insured.

You may be related to the insured person in one of several ways and be entitled to benefits as his or her child, i.e., as a natural child, legally adopted child, stepchild, grandchild, stepgrandchild, or equitably adopted child. For details on how we determine your relationship to the insured person, see §§ 404.355 through 404.359.

[63 FR 57593, Oct. 28, 1998]

§ 404.355 Who is the insured's natural child?

(a) *Eligibility as a natural child.* You may be eligible for benefits as the insured's natural child if any of the following conditions is met:

(1) You could inherit the insured's personal property as his or her natural child under State inheritance laws, as described in paragraph (b) of this section.

(2) You are the insured's natural child and the insured and your mother or father went through a ceremony which would have resulted in a valid marriage between them except for a ''legal impediment'' as described in § 404.346(a).

(3) You are the insured's natural child and your mother or father has not married the insured, but the insured has either acknowledged in writing that you are his or her child, been decreed by a court to be your father or mother, or been ordered by a court to contribute to your support because you are his or her child. If the insured is deceased, the acknowledgment, court decree, or court order must have been made or issued before his or her death. To determine whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a), the written acknowledgment, court decree, or court order will be considered to have occurred on the first day of the month in which it actually occurred.

(4) Your mother or father has not married the insured but you have evidence other than the evidence described in paragraph (a)(3) of this section to show that the insured is your natural father or mother. Additionally, you must have evidence to show that the insured was either living with you or contributing to your support at the time you applied for benefits. If the insured is not alive at the time of your application, you must have evidence to show that the insured was either living with you or contributing to your support when he or she died. See § 404.366 for an explanation of the terms ''living with'' and ''contributions for support.''

(b) *Use of State Laws*—(1) *General.* To decide whether you have inheritance rights as the natural child of the insured, we use the law on inheritance rights that the State courts would use to decide whether you could inherit a child's share of the insured's personal property if the insured were to die without leaving a will. If the insured is living, we look to the laws of the State where the insured has his or her permanent home when you apply for benefits. If the insured is deceased, we look to the laws of the State where the insured had his or her permanent home when he or she died. If the insured's permanent home is not or was not in one of the 50 States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, we will look to the laws of the District of Columbia. For a definition of permanent home, see § 404.303.

For a further discussion of the State laws we use to determine whether you qualify as the insured's natural child, see paragraphs (b)(3) and (b)(4) of this section. If these laws would permit you to inherit the insured's personal property as his or her child, we will consider you the child of the insured.

(2) *Standards.* We will not apply any State inheritance law requirement that an action to establish paternity must be taken within a specified period of time measured from the worker's death or the child's birth, or that an action to establish paternity must have been started or completed before the worker's death. If applicable State inheritance law requires a court determination of paternity, we will not require that you obtain such a determination but will decide your paternity by using the standard of proof that the State court would use as the basis for a determination of paternity.

(3) *Insured is living.* If the insured is living, we apply the law of the State where the insured has his or her permanent home when you file your application for benefits. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we look at all versions of State law that were in effect from the first month for which you could be entitled to benefits up until the time of our final decision and apply the version of State law that is most beneficial to you.

(4) *Insured is deceased.* If the insured is deceased, we apply the law of the State where the insured had his or her permanent home when he or she died. We apply the version of State law in effect when we make our final decision on your application for benefits. If you do not qualify as a child of the insured under that version of State law, we will apply the version of State law that was in effect at the time the insured died, or any version of State law in effect from the first month for which you could be entitled to benefits up until our final decision on your application. We will apply whichever version is most beneficial to you. We use the following rules to determine the law in effect as of the date of death:

(i) If a State inheritance law enacted after the insured's death indicates that the law would be retroactive to the time of death, we will apply that law; or

(ii) If the inheritance law in effect at the time of the insured's death was later declared unconstitutional, we will apply the State law which superseded the unconstitutional law.

[63 FR 57593, Oct. 28, 1998]

§ 404.356 Who is the insured's legally adopted child.

You may be eligible for benefits as the insured's child if you were legally adopted by the insured. If you were legally adopted after the insured's death by his or her surviving spouse you may also be considered the insured's legally adopted child. We apply the adoption laws of the State or foreign country where the adoption took place, not the State inheritance laws described in § 404.355, to determine whether you are the insured's legally adopted child.

[44 FR 34481, June 15, 1979, as amended at 63 FR 57594, Oct. 28, 1998]

§ 404.357 Who is the insured's stepchild.

You may be eligible for benefits as the insured's stepchild if, after your birth, your natural or adopting parent married the insured. You also may be eligible as a stepchild if you were conceived prior to the marriage of your natural parent to the insured but were born after the marriage and the insured is not your natural parent. The marriage between the insured and your parent must be a valid marriage under State law or a marriage which would be valid except for a *legal impediment* described in § 404.346(a). If the insured is alive when you apply, you must have been his or her stepchild for at least 1 year immediately preceding the day you apply. For purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), you will be considered to meet the one year duration requirement throughout the month in which the anniversary of the marriage occurs. If the insured is not alive when you apply, you must have been his or her stepchild for at least 9

months immediately preceding the day the insured died. This 9-month requirement will not have to be met if the marriage between the insured and your parent lasted less than 9 months under the conditions described in §404.335(a)(2).

[48 FR 21928, May 16, 1983, as amended at 64 FR 14608, Mar. 26, 1999]

§ 404.358 Who is the insured's grandchild or stepgrandchild.

(a) *Grandchild and stepgrandchild defined.* You may be eligible for benefits as the insured's grandchild or stepgrandchild if you are the natural child, adopted child, or stepchild of a person who is the insured's child as defined in §§ 404.355 through 404.357, or § 404.359. Additionally, for you to be eligible as a grandchild or stepgrandchild, your natural or adoptive parents must have been either deceased or under a disability, as defined in § 404.1501(a), at the time your grandparent or stepgrandparent became entitled to old-age or disability benefits or died; or if your grandparent or stepgrandparent had a period of disability that continued until he or she became entitled to benefits or died, at the time the period of disability began. If your parent is deceased, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), your parent will be considered to be deceased as of the first day of the month of death.

(b) *Legally adopted grandchild or stepgrandchild.* If you are the insured's grandchild or stepgrandchild and you are legally adopted by the insured or by the insured's surviving spouse after his or her death, you are considered an adopted child and the dependency requirements of § 404.362 must be met.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21928, May 16, 1983]

§ 404.359 Who is the insured's equitably adopted child.

You may be eligible for benefits as an equitably adopted child if the insured had agreed to adopt you as his or her child but the adoption did not occur. The agreement to adopt you must be one that would be recognized under State law so that you would be able to inherit a child's share of the insured's personal property if he or she were to die without leaving a will. The agreement must be in whatever form, and you must meet whatever requirements for performance under the agreement, that State law directs. If you apply for child's benefits after the insured's death, the law of the State where the insured had his or her permanent home at the time of his or her death will be followed. If you apply for child's benefits during the insured's life, the law of the State where the insured has his or her permanent home at the time or your application will be followed.

§ 404.360 When a child is dependent upon the insured person.

One of the requirements for entitlement to child's benefits is that you be dependent upon the insured. The evidence you need to prove your dependency is determined by how you are related to the insured. To prove your dependency you may be asked to show that at a specific time you lived with the insured, that you received contributions for your support from the insured, or that the insured provided at least one-half of your support. These dependency requirements, and the time at which they must be met, are explained in §§ 404.361 through 404.365. The terms *living with, contributions for support,* and *one-half support* are defined in § 404.366.

§ 404.361 When a natural child is dependent.

(a) *Dependency of natural child.* If you are the insured's natural child, as defined in § 404.355, you are considered dependent upon him or her, except as stated in paragraph (b) of this section.

(b) *Dependency of natural child legally adopted by someone other than the insured.* (1) Except as indicated in paragraph (b)(2) of this section, if you are legally adopted by someone other than the insured (your natural parent) during the insured's lifetime, you are considered dependent upon the insured only if the insured was either living with you or contributing to your support at one of the following times:

(i) When you applied;

(ii) When the insured died; or

(iii) If the insured had a period of disability that lasted until he or she became entitled to disability or old-age benefits or died, at the beginning of the period of disability or at the time he or she became entitled to disability or old-age benefits.

(2) You are considered dependent upon the insured (your natural parent) if:

(i) You were adopted by someone other than the insured after you applied for child's benefits; or

(ii) The insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits or died, and you are adopted by someone other than the insured after the beginning of that period of disability.

[64 FR 14608, Mar. 26, 1999]

§ 404.362 When a legally adopted child is dependent.

(a) *General.* If you were legally adopted by the insured before he or she became entitled to old-age or disability benefits, you are considered dependent upon him or her. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits during the life of the insured, you must meet the dependency requirements stated in paragraph (b) of this section. If you were legally adopted by the insured after he or she became entitled to old-age or disability benefits and you apply for child's benefits after the death of the insured, you are considered dependent upon him or her. If you were adopted after the insured's death by his or her surviving spouse, you may be considered dependent upon the insured only under the conditions described in paragraph (c) of this section.

(b) *Adoption by the insured after he or she became entitled to benefits.* (1) *General.* If you are legally adopted by the insured after he or she became entitled to benefits and you are not the insured's natural child or stepchild, you are considered dependent on the insured during his or her lifetime only if—

(i) You had not attained age 18 when adoption proceedings were started, and your adoption was issued by a court of competent jurisdiction within the United States; or

(ii) You had attained age 18 before adoption proceedings were started; your adoption was issued by a court of competent jurisdiction within the United States; and you were living with or receiving at least one-half of your support from the insured for the year immediately preceding the month in which your adoption was issued.

(2) *Natural child and stepchild.* If you were legally adopted by the insured after he or she became entitled to benefits and you are the insured's natural child or stepchild, you are considered dependent upon the insured.

(c) *Adoption by the insured's surviving spouse*—(1) *General.* If you are legally adopted by the insured's surviving spouse after the insured's death, you are considered dependent upon the insured as of the date of his or her death if—

(i) You were either living with or receiving at least one-half of your support from the insured at the time of his or her death; and,

(ii) The insured had started adoption proceedings before he or she died; or if the insured had not started the adoption proceedings before he or she died, his or her surviving spouse began and completed the adoption within 2 years of the insured's death.

(2) *Grandchild or stepgrandchild adopted by the insured's surviving spouse.* If you are the grandchild or stepgrandchild of the insured and any time after the death of the insured you are legally adopted by the insured's surviving spouse, you are considered the dependent child of the insured as of the date of his or her death if—

(i) Your adoption took place in the United States;

(ii) At the time of the insured's death, your natural, adopting or stepparent was not living in the insured's household and making regular contributions toward your support; and

(iii) You meet the dependency requirements stated in § 404.364.

[44 FR 34481, June 15, 1979; 44 FR 56691, Oct. 2, 1979, as amended at 56 FR 24000, May 28, 1991; 57 FR 3938, Feb. 3, 1992]

§ 404.363 When a stepchild is dependent.

If you are the insured's stepchild, as defined in § 404.357, you are considered dependent upon him or her if you were either living with or receiving at least one-half of your support from him or her at one of these times—

(a) When you applied;

(b) When the insured died; or

(c) If the insured had a period of disability that lasted until his or her death or entitlement to disability or old-age benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.364 When a grandchild or stepgrandchild is dependent.

If you are the insured's grandchild or stepgrandchild, as defined in § 404.358(a), you are considered dependent upon the insured if—

(a) You began living with the insured before you became 18 years old; and

(b) You were living with the insured in the United States and receiving at least one-half of your support from him for the year before he or she became entitled to old-age or disability benefits or died; or if the insured had a period of disability that lasted until he or she became entitled to benefits or died, for the year immediately before the month in which the period of disability began. If you were born during the 1-year period, the insured must have lived with you and provided at least one-half of your support for *substantially all* of the period that begins on the date of your birth. The term *substantially all* is defined in § 404.362(b)(1)(iii).

§ 404.365 When an equitably adopted child is dependent.

If you are the insured's equitably adopted child, as defined in § 404.359, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at the time of his or her death. If your equitable adoption is found to have occurred after the insured became entitled to old-age or disability benefits, your dependency cannot be established during the insured's life. If your equitable adoption is found to have occurred before the insured became entitled to old-age or disability benefits, you are considered dependent upon him or her if you were either living with or receiving contributions for your support from the insured at one of these times—

(a) When you applied; or

(b) If the insured had a period of disability that lasted until he or she became entitled to old-age or disability benefits, at the beginning of the period of disability or at the time the insured became entitled to benefits.

§ 404.366 "Contributions for support," "one-half support," and "living with" the insured defined—determining first month of entitlement.

To be eligible for child's or parent's benefits, and in certain Government pension offset cases, you must be dependent upon the insured person at a particular time or be assumed dependent upon him or her. What it means to be a dependent child is explained in §§ 404.360 through 404.365; what it means to be a dependent parent is explained in § 404.370(f); and the Government pension offset is explained in § 404.408a. Your dependency upon the insured person may be based upon whether at a specified time you were receiving *contributions for your support* or *one-half of your support* from the insured person, or whether you were *living with* him or her. These terms are defined in paragraphs (a) through (c) of this section.

(a) *Contributions for support.* The insured makes a contribution for your support if the following conditions are met:

(1) The insured gives some of his or her own cash or goods to help support you. Support includes food, shelter, routine medical care, and other ordinary and customary items needed for your maintenance. The value of any goods the insured contributes is the same as the cost of the goods when he or she gave them for your support. If the insured provides services for you that would otherwise have to be paid for, the cash value of his or her services may be considered a contribution for your support. An example of this would be work the insured does to repair your home. The insured person is making a contribution for your support

if you receive an allotment, allowance, or benefit based upon his or her military pay, veterans' pension or compensation, or social security earnings.

(2) Contributions must be made regularly and must be large enough to meet an important part of your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. If the insured person only provides gifts or donations once in a while for special purposes, they will not be considered contributions for your support. Although the insured's contributions must be made on a regular basis, temporary interruptions caused by circumstances beyond the insured person's control, such as illness or unemployment, will be disregarded unless during this interrruption someone else takes over responsibility for supporting you on a permanent basis.

(b) *One-half support.* The insured person provides one-half of your support if he or she makes regular contributions for your ordinary living costs; the amount of these contributions equals or exceeds one-half of your ordinary living costs; and any income (from sources other than the insured person) you have available for support purposes is one-half or less of your ordinary living costs. We will consider any income which is available to you for your support whether or not that income is actually used for your ordinary living costs. Ordinary living costs are the costs for your food, shelter, routine medical care, and similar necessities. A contribution may be in cash, goods, or services. The insured is not providing at least one-half of your support unless he or she has done so for a reasonable period of time. Ordinarily we consider a reasonable period to be the 12-month period immediately preceding the time when the one-half support requirement must be met under the rules in §§ 404.362(c)(1) and 404.363 (for child's benefits), in § 404.370(f) (for parent's benefits) and in § 404.408a(c) (for benefits where the Government pension offset may be applied). A shorter period will be considered reasonable under the following circumstances:

(1) At some point within the 12-month period, the insured either begins or stops providing at least one-half of your support on a permanent basis and this is a change in the way you had been supported up to then. In these circumstances, the time from the change up to the end of the 12-month period will be considered a reasonable period, unless paragraph (b)(2) of this section applies. The change in your source of support must be permanent and not temporary. Changes caused by seasonal employment or customary visits to the insured's home are considered temporary.

(2) The insured provided one-half or more of your support for at least 3 months of the 12-month period, but was forced to stop or reduce contributions because of circumstances beyond his or her control, such as illness or unemployment, and no one else took over the responsibility for providing at least one-half of your support on a permanent basis. Any support you received from a public assistance program is not considered as a taking over of responsibility for your support by someone else. Under these circumstances, a reasonable period is that part of the 12-month period before the insured was forced to reduce or stop providing at least one-half of your support.

(c) *''Living with'' the insured.* You are living with the insured if you ordinarily live in the same home with the insured and he or she is exercising, or has the right to exercise, parental control and authority over your activities. You are living with the insured during temporary separations if you and the insured expect to live together in the same place after the separation. Temporary separations may include the insured's absence because of active military service or imprisonment if he or she still exercises parental control and authority. However, you are not considered to be living with the insured if you are in active military service or in prison. If *living with* is used to establish dependency for your eligibility to child's benefits and the date your application is filed is used for establishing the point for determining dependency, you must have been living with the insured throughout the month your application is filed in order to be entitled to benefits for that month.

(d) *Determining first month of entitlement.* In evaluating whether dependency is established under paragraph (a), (b), or (c) of this section, for purposes of determining whether the conditions of entitlement are met *throughout* the first month as stated in § 404.352(a)(2)(i), we will not use the temporary separation or temporary interruption rules.

[44 FR 34481, June 15, 1979, as amended at 45 FR 65540, Oct. 3, 1980; 48 FR 21928, May 16, 1983; 52 FR 26955, July 17, 1987; 64 FR 14608, Mar. 26, 1999]

§ 404.367 When you are a "full-time elementary or secondary school student".

You may be eligible for child's benefits if you are a full-time elementary or secondary school student. For the purposes of determining whether the conditions of entitlement are met throughout the first month as stated in § 404.352(a)(2)(i), if you are entitled as a student on the basis of attendance at an elementary or secondary school, you will be considered to be in full-time attendance for a month during any part of which you are in full-time attendance. You are a full-time elementary or secondary school student if you meet all the following conditions:

(a) You attend a school which provides elementary or secondary education as determined under the law of the State or other jurisdiction in which it is located. Participation in the following programs also meets the requirements of this paragraph:

(1) You are instructed in elementary or secondary education at home in accordance with a home school law of the State or other jurisdiction in which you reside; or

(2) You are in an independent study elementary or secondary education program in accordance with the law of the State or other jurisdiction in which you reside which is administered by the local school or school district/jurisdiction.

(b) You are in full-time attendance in a day or evening noncorrespondence course of at least 13 weeks duration and you are carrying a subject load which is considered full-time for day students under the institution's standards and practices. If you are in a home schooling program as described in paragraph (a)(1) of this section, you must be carrying a subject load which is considered full-time for day students under standards and practices set by the State or other jurisdiction in which you reside;

(c) To be considered in full-time attendance, your scheduled attendance must be at the rate of at least 20 hours per week unless one of the exceptions in paragraphs (c) (1) and (2) of this section applies. If you are in an independent study program as described in paragraph (a)(2) of this section, your number of hours spent in school attendance are determined by combining the number of hours of attendance at a school facility with the agreed upon number of hours spent in independent study. You may still be considered in full-time attendance if your scheduled rate of attendance is below 20 hours per week if we find that:

(1) The school attended does not schedule at least 20 hours per week and going to that particular school is your only reasonable alternative; or

(2) Your medical condition prevents you from having scheduled attendance of at least 20 hours per week. To prove that your medical condition prevents you from scheduling 20 hours per week, we may request that you provide appropriate medical evidence or a statement from the school.

(d) You are not being paid while attending the school by an employer who has requested or required that you attend the school;

(e) You are in grade 12 or below; and

(f) You are not subject to the provisions in § 404.468 for nonpayment of benefits to certain prisoners and certain other inmates of publicly funded institutions.

[48 FR 21928, May 16, 1983, as amended at 48 FR 55452, Dec. 13, 1983; 56 FR 35999, July 30, 1991; 61 FR 38363, July 24, 1996]

§ 404.368 When you are considered a full-time student during a period of nonattendance.

If you are a full-time student, your eligibility may continue during a period of nonattendance (including part-time attendance) if all the following conditions are met:

(a) The period of nonattendance is 4 consecutive months or less;

(b) You show us that you intend to resume your studies as a full-time student at the end of the period or at the end of the period you are a full-time student; and

(c) The period of nonattendance is not due to your expulsion or suspension from the school.

[48 FR 21929, May 16, 1983]

PARENT'S BENEFITS

§ 404.370 Who is entitled to parent's benefits.

You may be entitled to parent's benefits on the earnings record of someone who has died and was fully insured. You are entitled to these benefits if all the following conditions are met:

(a) You are related to the insured person as his or her parent in one of the ways described in § 404.374.

(b) You are at least 62 years old.

(c) You have not married since the insured person died.

(d) You apply.

(e) You are not entitled to an old-age benefit equal to or larger than the parent's benefit amount.

(f) You were receiving at least one-half of your support from the insured at the time he or she died, or at the beginning of any period of disability he or she had that continued up to death. See § 404.366(b) for a definition of *one-half support.* If you were receiving one-half of your support from the insured at the time of the insured's death, you must give us proof of this support within 2 years of the insured's death. If you were receiving one-half of your support from the insured at the time his or her period of disability began, you must give us proof of this support within 2 years of the month in which the insured filed his or her application for the period of disability. You must file the evidence of support even though you may not be eligible for parent's benefits until a later time. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to provide proof of support within the 2-year period, we will consider the proof you give us as though it were provided within the 2-year period. Good cause does not exist if you were informed of the need to provide the proof within the 2-year period and you neglected to do so or did not intend to do so. Good cause will be found to exist if you did not provide the proof within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get proof of the support without realizing that you could submit the proof after you gave us some other evidence of that support; or

(iv) Unusual or unavoidable circumstances that show you could not reasonably be expected to know of the 2-year time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

§ 404.371 When parent's benefits begin and end.

(a) You are entitled to parent's benefits beginning with the first month covered by your application in which you meet all the other requirements for entitlement.

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

(1) You become entitled to an old-age benefit equal to or larger than the parent's benefit.

(2) You marry, unless your marriage is to someone entitled to wife's, husband's, widow's, widower's, mother's, father's, parent's or disabled child's benefits. If you marry a person entitled to these benefits, the marriage does not affect your benefits.

(3) You die.

[44 FR 34481, June 15, 1979, as amended at 49 FR 24116, June 12, 1984]

§ 404.373 Parent's benefit amounts.

Your parent's monthly benefit before any reduction that may be made as explained in § 404.304, is figured in one of the following ways:

(a) *One parent entitled.* Your parent's monthly benefit is equal to 82½ percent

of the insured person's primary insurance amount if you are the only parent entitled to benefits on his or her earnings record.

(b) *More than one parent entitled.* Your parent's monthly benefit is equal to 75 percent of the insured person's primary insurance amount if there is another parent entitled to benefits on his or her earnings record.

§ 404.374 Parent's relationship to the insured.

You may be eligible for benefits as the insured person's parent if—

(a) You are the mother or father of the insured and would be considered his or her parent under the laws of the State where the insured had a permanent home when he or she died;

(b) You are the adoptive parent of the insured and legally adopted him or her before the insured person became 16 years old; or

(c) You are the stepparent of the insured and you married the insured's parent or adoptive parent before the insured became 16 years old. The marriage must be valid under the laws of the State where the insured had his or her permanent home when he or she died. See § 404.303 for a definition of *permanent home.*

SPECIAL PAYMENTS AT AGE 72

§ 404.380 General.

Some older persons had little or no chance to become fully insured for regular social security benefits during their working years. For those who became 72 years old several years ago but are not fully insured, a *special payment* may be payable as described in the following sections.

§ 404.381 Who is entitled to special age 72 payments.

You are entitled to a special age 72 payment if—

(a) You have attained the age of 72; and

(1) You attained such age before 1968; or

(2) You attained such age after 1967—or, for applications filed after November 5, 1990, you attained age 72 after 1967 and before 1972—and have at least 3 quarters of coverage for each calendar year elapsing after 1966 and before the year in which you attained age 72 (see subpart B for a description of quarters of coverage);

(b) You reside in one of the 50 States, the District of Columbia, or the Northern Mariana Islands;

(c) You apply; and

(d) You are a U.S. citizen or a citizen of the Northern Mariana Islands; or you are an alien who was legally admitted for permanent residence in the United States and who has resided here continuously for 5 years. Residence in the United States includes residence in the Northern Mariana Islands, Guam, American Samoa, Puerto Rico, and the Virgin Islands.

[44 FR 34481, June 15, 1979, as amended at 57 FR 21598, May 21, 1992]

§ 404.382 When special age 72 payments begin and end.

(a) Your entitlement to the special age 72 payment begins with the first month covered by your application in which you meet all the other requirements for entitlement.

(b) Your entitlement to this payment ends with the month before the month of your death.

§ 404.383 Special age 72 payment amounts.

(a) *Payment from May 1983 on.* If you are entitled to special age 72 payments from May 1983 on, you will receive a monthly payment of $125.60. If your spouse is also entitled to special age 72 payments, he or she will also receive $125.60. This amount, first payable for June 1982, will be increased when *cost-of-living* adjustments of Social Security benefits occur. This special payment may be reduced, suspended or not paid at all as explained in § 404.384.

(b) *Payment prior to May 1983.* If a husband or a single individual is entitled to special age 72 payments for months prior to May 1983, the amount payable was $125.60 for the months since June 1982. The wife received an amount approximiately one-half the husband's amount (i.e., $63.00 for months in the period June 1982-April 1983).

[49 FR 24116, June 12, 1984]

§ 404.384 Reductions, suspensions, and nonpayments of special age 72 payments.

(a) *General.* Special age 72 payments may not be paid for any month you receive public assistance payments. The payment may be reduced if you or your spouse are eligible for a government pension. In some instances, the special payment may not be paid while you are outside the United States. The rules on when special payments may be suspended, reduced, or not paid are provided in paragraphs (b) through (e) of this section.

(b) *Suspension of special age 72 payments when you receive certain assistance payments.* You cannot receive the special payment if supplemental security income or aid to families with dependent children (AFDC) payments are payable to you, or if your needs are considered in setting the amounts of these assistance payments made to someone else. However, if these assistance payments are stopped, you may receive the special payment beginning with the last month for which the assistance payments were paid.

(c) *Reduction of special age 72 payments when you or your spouse are eligible for a government pension.* Special payments are reduced for any regular government pension (or lump-sum payment given instead of a pension) that you or your spouse are eligible for at retirement. A government pension is any annuity, pension, or retirement pay from the Federal Government, a State government or political subdivision, or any organization wholly owned by the Federal or State government. Also included as a government pension is any social security benefit. The term government pension does not include workmen's compensation payments or Veterans Administration payments for a service-connected disability or death.

(d) *Amount of reduction because of a government pension.* If you are eligible for a government pension, the amount of the pension will be subtracted from your special age 72 payment. If your spouse is eligible for a government pension but is not entitled to the special payment, your special payment is reduced (after any reduction due to your own government pension) by the difference between the pension amount and the full special payment amount. If both you and your spouse are entitled to the special payment, each spouse's payment is first reduced by the amount of his or her own government pension (if any). Then, the wife's special payment is reduced by the amount that the husband's government pension exceeds the full special payment. The husband's special payment is also reduced by the amount that the wife's government pension exceeds the full special payment.

(e) *Nonpayment of special age 72 payments when you are not residing in the United States.* No special payment is due you for any month you are not a resident of one of the 50 States, the District of Columbia, or the Northern Mariana Islands. Also, payment to you may not be permitted under the rules in § 404.463 if you are an alien living outside the United States.

[44 FR 34481, June 15, 1979, as amended at 49 FR 24116, June 12, 1984]

LUMP-SUM DEATH PAYMENT

§ 404.390 General.

If a person is fully or currently insured when he or she dies, a lump-sum death payment of $255 may be paid to the widow or widower of the deceased if he or she was living in the same household with the deceased at the time of his or her death. If the insured is not survived by a widow(er) who meets this requirement, all or part of the $255 payment may be made to someone else as described in § 404.392.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983; 61 FR 41330, Aug. 8, 1996]

§ 404.391 Who is entitled to the lump-sum death payment as a widow or widower who was living in the same household.

You are entitled to the lump-sum death payment as a widow or widower who was living in the same household if—

(a) You are the widow or widower of the deceased insured individual based upon a relationship described in § 404.345 or § 404.346;

(b) You apply for this payment within two years after the date of the insured's death. You need not apply

again if, in the month prior to the death of the insured, you were entitled to wife's or husband's benefits on his or her earnings record; and

(c) You were living in the same household with the insured at the time of his or her death. The term *living in the same household* is defined in § 404.347.

[44 FR 34481, June 15, 1979, as amended at 48 FR 21929, May 16, 1983]

§ 404.392 Who is entitled to the lump-sum death payment when there is no widow(er) who was living in the same household.

(a) *General.* If the insured individual is not survived by a widow(er) who meets the requirements of § 404.391, the lump-sum death payment shall be paid as follows:

(1) To a person who is entitled (or would have been entitled had a timely application been filed) to widow's or widower's benefits (as described in § 404.335) or mother's or father's benefits (as described in § 404.339) on the work record of the deceased worker for the month of that worker's death; or

(2) If no person described in (1) survives, in equal shares to each person who is entitled (or would have been entitled had a timely application been filed) to child's benefits (as described in § 404.350) on the work record of the deceased worker for the month of that worker's death.

(b) *Application requirement.* A person who meets the requirements of paragraph (a)(1) of this section need not apply to receive the lump-sum death payment if, for the month prior to the death of the insured, that person was entitled to wife's or husband's benefits on the insured's earnings record. Otherwise, an application must be filed within 2 years of the insured's death.

[48 FR 21929, May 16, 1983; 61 FR 41330, Aug. 8, 1996]

Subpart E—Deductions; Reductions; and Nonpayments of Benefits

AUTHORITY: Secs. 202, 203, 204 (a) and (e), 205 (a) and (c), 222(b), 223(e), 224, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 403, 404 (a) and (e), 405 (a) and (c), 422(b), 423(e), 424a, 425, and 902(a)(5)).

SOURCE: 32 FR 19159, Dec. 20, 1967, unless otherwise noted.

§ 404.401 Deduction, reduction, and nonpayment of monthly benefits or lump-sum death payments.

Under certain conditions, the amount of a monthly insurance benefit (see §§ 404.380 through 404.384 of this part for provisions concerning special payments at age 72) or the lump-sum death payment as calculated under the pertinent provisions of sections 202 and 203 of the Act (including reduction for age under section 202(q) of a monthly benefit) must be increased or decreased to determine the amount to be actually paid to a beneficiary. Increases in the amount of a monthly benefit or lump-sum death payment are based upon recomputation and recalculations of the primary insurance amount (see subpart C of this part). A decrease in the amount of a monthly benefit or lump-sum death payment is required in the following instances:

(a) *Reductions.* A reduction of a person's monthly benefit is required where:

(1) The total amount of the monthly benefits payable on an earnings record exceeds the maximum that may be paid (see § 404.403);

(2) An application for monthly benefits is effective for a month during a retroactive period, and the maximum has already been paid for that month or would be exceeded if such benefit were paid for that month (see § 404.406);

(3) An individual is entitled to old-age or disability insurance benefits in addition to any other monthly benefit (see § 404.407);

(4) An individual under age 65 is concurrently entitled to disability insurance benefits and to certain public disability benefits (see § 404.408);

(5) An individual is entitled in a month to a widow's or widower's insurance benefit that is reduced under section 202 (e)(4) or (f)(5) of the Act and to any other monthly insurance benefit other than an old-age insurance benefit (see § 404.407(b)); or

(6) An individual is entitled in a month to old-age, disability, wife's, husband's, widow's, or widower's insurance benefit and reduction is required under section 202(q) of the Act (see § 404.410).

(b) *Deductions.* A deduction from a monthly benefit or a lump-sum death payment may be required because of:

(1) An individual's earnings or work (see §§ 404.415 and 404.417);

(2) Failure of certain beneficiaries receiving wife's or mother's insurance benefits to have a child in her care (see § 404.421);

(3) The earnings or work of an old-age insurance beneficiary where a wife, husband, or child is also entitled to benefits (see §§ 404.415 and 404.417);

(4) Failure to report within the prescribed period either certain work outside the United States or not having the care of a child (see § 404.451);

(5) Failure to report within the prescribed period earnings from work in employment or self-employment (see § 404.453);

(6) Refusal to accept rehabilitation services in certain cases (see § 404.422); or

(7) Certain taxes which were neither deducted from the wages of maritime employees nor paid to the Federal Government (see § 404.457).

(c) *Adjustments.* Adjustments may be required because an error has been made in payments to an individual (see subpart F of this part).

(d) *Nonpayments.* Nonpayment of monthly benefits may be required because:

(1) The individual is an alien who has been outside the United States for more than 6 months (see § 404.460);

(2) The individual on whose earnings record entitlement is based has been deported (see § 404.464);

(3) The individual is engaged in substantial gainful activity while entitled to disability insurance benefits based on ''statutory blindness'' (see § 404.467); or

(4) The individual has not provided satisfactory proof that he or she has a Social Security number or has not properly applied for a Social Security number (see § 404.469).

(e) *Recalculation.* A reduction by recalculation of a benefit amount may be prescribed because an individual has been convicted of certain offenses (see § 404.465) or because the primary insurance amount is recalculated (see subpart C of this part).

(f) *Suspensions.* Suspension of monthly benefits may be required pursuant to section 203(h)(3) of the Act (the Social Security Administration has information indicating that work deductions may reasonably be expected for the year), or pursuant to section 225 of the Act (the Social Security Administration has information indicating a beneficiary is no longer disabled).

[40 FR 30813, July 23, 1975, as amended at 48 FR 37016, Aug. 16, 1983; 56 FR 41789, Aug. 23, 1991; 65 FR 16813, Mar. 30, 2000]

§ 404.401a When we do not pay benefits because of a disability beneficiary's work activity.

If you are receiving benefits because you are disabled or blind as defined in title II of the Social Security Act, we will stop your monthly benefits even though you have a disabling impairment (§ 404.1511), if you engage in substantial gainful activity during the reentitlement period (§ 404.1592a) following completion of the trial work period (§ 404.1592). You will, however, be paid benefits for the first month after the trial work period in which you do substantial gainful activity and the two succeeding months, whether or not you do substantial gainful activity in those two months. If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period. Earnings from work activity during a trial work period will not stop your benefits.

[49 FR 22271, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993]

§ 404.402 Interrelationship of deductions, reductions, adjustments, and nonpayment of benefits.

(a) *Deductions, reductions, adjustment.* Deductions because of earnings or work (see §§ 404.415 and 404.417); failure to have a child ''in her care'' (see § 404.421); refusal to accept rehabilitation services (see § 404.422); as a penalty for failure to timely report noncovered work outside the United States, failure by a woman to report that she no longer has a child ''in her care,'' or failure to timely report earnings (see §§ 404.451 and 404.453); because of unpaid

maritime taxes (see § 404.457); or nonpayments because of drug addiction and alcoholism to individuals other than an insured individual who are entitled to benefits on the insured individual's earnings record are made:

(1) Before making any reductions because of the *maximum* (see § 404.403),

(2) Before applying the benefit *rounding* provisions (see § 404.304(f)), and,

(3) Except for deductions imposed as a penalty (see §§ 404.451 and 404.453), before making any adjustment necessary because an error has been made in the payment of benefits (see subpart F). However, for purposes of charging excess earnings for taxable years beginning after December 1960 or ending after June 1961, see paragraph (b) of this section and § 404.437 for reductions that apply before such charging.

(b) *Reductions, nonpayments.* (1) Reduction because of the *maximum* (see § 404.403) is made:

(i) Before reduction because of simultaneous entitlement to old-age or disability insurance benefits and to other benefits (see § 404.407);

(ii) Before reduction in benefits for age (see §§ 404.410 through 404.413);

(iii) Before adjustment necessary because an error has been made in the payment of benefits (see subpart F of this part);

(iv) Before reduction because of entitlement to certain public disability benefits provided under Federal, State, or local laws or plans (see § 404.408);

(v) Before nonpayment of an individual's benefits because he is an alien living outside the United States for 6 months (see § 404.460), or because of deportation (see § 404.464); and

(vi) Before the redetermination of the amount of benefit payable to an individual who has been convicted of certain offenses (see § 404.465).

(2) Reduction of benefits because of entitlement to certain public disability benefits (see § 404.408) is made before deduction:

(i) Under section 203 of the Act relating to work (see §§ 404.415, 404.417, 404.451, and 404.453) and failure to have care of a child (see §§ 404.421 and 404.451), and

(ii) Under section 222(b) of the Act on account of refusal to accept rehabilitation services (see § 404.422).

(3) Reduction of the benefit of a spouse who is receiving a Government pension (see § 404.408(a)) is made after the withholding of payments as listed in paragraph (d)(1) of this section and after reduction because of receipt of certain public disability benefits (paragraph (b)(2) of this section).

(c) *Alien outside the United States; deportation nonpayment—deduction.* If an individual is subject to nonpayment of a benefit for a month under § 404.460 or § 404.464, no deduction is made from his benefit for that month under § 404.415, § 404.417, or § 404.421, and no deduction is made because of that individual's work from the benefit of any person entitled or deemed entitled to benefits under § 404.420, on his earnings record, for that month.

(d) *Order of priority—deductions and other withholding provisions.* Deductions and other withholding provisions are applied in accordance with the following order of priority:

(1) Current nonpayments under §§ 404.460, 404.464, 404.465, 404.467, and 404.469;

(2) Current reductions under § 404.408;

(3) Current reductions under § 404.408a;

(4) Current deductions under §§ 404.417, 404.421, and 404.422;

(5) Current withholding of benefits under § 404.456;

(6) Unpaid maritime tax deductions (§ 404.457);

(7) Withholdings to recover overpayments (see subpart F of this part);

(8) Penalty deductions under §§ 404.451 and 404.453.

[40 FR 30813, July 23, 1975, as amended at 44 FR 29047, May 18, 1979; 48 FR 37016, Aug. 16, 1983; 48 FR 46148, Oct. 11, 1983; 56 FR 41789, Aug. 23, 1991; 60 FR 8146, Feb. 10, 1995]

§ 404.403 Reduction where total monthly benefits exceed maximum family benefits payable.

(a) *General.* (1) The Social Security Act limits the amount of monthly benefits that can be paid for any month based on the earnings of an insured individual. If the total benefits to which all persons are entitled on one earnings record exceed a maximum amount prescribed by law, then those benefits must be reduced so that they do not exceed that maximum.

(2) The method of determining the total benefits payable (the *family maximum*) depends on when the insured individual died or became eligible, whichever is earlier. For purposes of this section, the year in which the insured individual becomes eligible refers generally to the year in which the individual attains age 62 or becomes disabled. However, where eligibility or death is in 1979 or later, the year of death, attainment of age 62, or beginning of current disability does not control if the insured individual was entitled to a disability benefit within the 12 month period preceding current eligibility or death. Instead the year in which the individual became eligible for the former disability insurance benefit is the year of eligibility.

(3) The benefits of an individual entitled as a divorced spouse or surviving divorced spouse will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record will be determined under this section as if no such divorced spouse or surviving divorced spouse were entitled to benefits.

(4) In any case where more than one individual is entitled to benefits as the spouse or surviving spouse of a worker for the same month, and at least one of those individuals is entitled based on a marriage not valid under State law (see §§ 404.345 and 404.346), the benefits of the individual whose entitlement is based on a valid marriage under State law will not be reduced pursuant to this section. The benefits of all other individuals entitled on the same record (unless excluded by paragraph (a)(3) of this section) will be determined under this section as if such validly married individual were not entitled to benefits.

(5) When a person entitled on a worker's earnings record is also entitled to benefits on another earnings record, we consider only the amount of benefits actually due or payable on the worker's record to the dually-entitled person when determining how much to reduce total monthly benefits payable on the worker's earnings record because of the maximum. We do not include, in total benefits payable, any amount not paid because of that person's entitlement on another earnings record (see § 404.407). The effect of this provision is to permit payment of up to the full maximum benefits to other beneficiaries who are not subject to a deduction or reduction. (See § 404.402 for other situations where we apply deductions or reductions before reducing total benefits for the maximum.)

Example 1: A wage earner, his wife and child are entitled to benefits. The wage earner's primary insurance amount is $600.00. His maximum is $900.00. Due to the maximum limit, the monthly benefits for the wife and child must be reduced to $150.00 each. Their original benefit rates are $300.00 each.

Maximum—$900.00
Subtract primary insurance amount—$600.00
Amount available for wife and child—$300.00
Divide by 2—$150.00 each for wife and child

The wife is also entitled to benefits on her own record of $120.00 monthly. This reduces her wife's benefit to $30.00. The following table illustrates this calculation.

Wife's benefit, reduced for maximum—$150.00
Subtract reduction due to dual entitlement—$120.00
Wife's benefit—$30.00

In computing the total benefits payable on the record, we disregard the $120.00 we cannot pay the wife. This allows us to increase the amount payable to the child to $270.00. The table below shows the steps in our calculation.

Amount available under maximum—$300.00
Subtract amount due wife after reduction due to entitlement to her own benefit—$30.00
Child's benefit—$270.00

EXAMPLE 2: A wage earner, his wife and 2 children are entitled to benefits. The wage earner's primary insurance amount is $1,250.00. His maximum is $2,180.00. Due to the maximum limit, the monthly benefits for the wife and children must be reduced to $310.00 each. Their original rates (50 percent of the worker's benefit) are $625.00 each. The following shows the calculation.

Maximum—$2,180.00
Subtract primary insurance amount—$1,250.00
Amount available for wife and children—$930.00
Divide by 3—$310 each for wife and children

The children are also entitled to benefits on their own records. Child one is entitled to $390.00 monthly and child two is entitled to $280.00 monthly. This causes a reduction in the benefit to child one to 0.00 and the benefit to child two to $30.00. Again, the following illustrates the calculation.

Benefit payable to child 1 reduced for maximum—$310.00

Subtract reduction due to dual entitlement—$390.00
Benefit payable to child 1—$0.00
Benefit payable to child 2, reduced for maximum—$310.00
Subtract reduction for dual entitlement—$280.00
Benefit payable to child 2—$30.00

In computing the total benefits payable on the record, we consider only the benefits actually paid to the children, or $30. This allows payment of an additional amount to the wife, increasing her benefit to $625.00. This is how the calculation works.

Amount available under maximum for wife and children—$930.00
Subtract amount due children after reduction due to entitlement to their own benefits—$30.00
Amount available for wife—$900.00
Amount payable to wife (original benefit)—$625.00

EXAMPLE 3: A wage earner, his wife and 4 children are entitled to benefits. The wage earner's primary insurance amount is $1,250.00. His maximum is $2,180.00. Due to the maximum limit, the monthly benefits for the wife and children must be reduced to $186.00 each. Their original rates are $625.00 each. This is how the calculation works.

Maximum—$2,180.00
Subtract primary insurance amount—$1,250.00
Amount available for wife and children—$930.00
Divide by 5—$186.00 each for wife and four children

Two children are also entitled to benefits on their own records. Child one is entitled to $390.00 monthly and child two is entitled to $280.00 monthly. This causes a reduction in the benefit to child one to $0.00 and the benefit to child two to $0.00. This calculation is as follows.

Benefit to child 1, reduced for maximum—$186.00
Subtract reduction due to dual entitlement—$390.00
Benefit payable to child 1—$0.00
Benefit to child 2, reduced for maximum—$186.00
Subtract reduction for dual entitlement—$280.00
Benefit payable to child two—$0.00

In computing the total benefits payable on the record, we disregard the $372.00 we cannot pay the children. This allows payment of an additional amount to the wife, and the two remaining children as follows:

Amount available under maximum for wife and children—$930.00
Subtract amount due child one and child two after reduction due to entitlement to their own benefits—$0.00
Amount available for wife and the other two children—$930.00
Amount payable to the wife and each of the remaining two children—$310.00

(b) *Eligibility or death before 1979.* Where more than one individual is entitled to monthly benefits for the same month on the same earnings record, a reduction in the total benefits payable for that month may be required (except in cases involving a *saving clause*—see § 404.405) if the maximum family benefit is exceeded. The maximum is exceeded if the total of the monthly benefits exceeds the amount appearing in column V of the applicable table in section 215(a) of the Act on the line on which appears in column IV the primary insurance amount of the insured individual whose earnings record is the basis for the benefits payable. Where the maximum is exceeded, the total benefits for each month after 1964 are reduced to the amount appearing in column V. However, when any of the persons entitled to benefits on the insured individual's earnings would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the basis of the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—

(1) The sum of the maximum amounts of benefits payable on the basis of the earnings records of all such insured individuals, or

(2) The last figure in column V of the applicable table in (or deemed to be in) section 215(a) of the Act. The *applicable* table refers to the table which is effective for the month the benefit is payable.

(c) *Eligible for old-age insurance benefits or dies in 1979.* If an insured individual becomes eligible for old-age insurance benefits or dies in 1979, the monthly maximum is as follows—

(1) 150 percent of the first $230 of the individual's primary insurance amount, plus

(2) 272 percent of the primary insurance amount over $230 but not over $332, plus

(3) 134 percent of the primary insurance amount over $332 but not over $433, plus

(4) 175 percent of the primary insurance amount over $433.

If the total of this computation is not a multiple of $0.10, it will be rounded to the next lower multiple of $0.10.

(d) *Eligible for old-age insurance benefits or dies after 1979.* (1) If an insured individual becomes eligible for old-age insurance benefits or dies after 1979, the monthly maximum is computed as in paragraph (c) of this section. However, the dollar amounts shown there will be updated each year as average earnings rise. This updating is done by first dividing the average of the total wages (see § 404.203(m)) for the second year before the individual dies or becomes eligible, by the average of the total wages for 1977. The result of that computation is then multiplied by each dollar amount in the formula in paragraph (c) of this section. Each updated dollar amount will be rounded to the nearer dollar; if the amount is an exact multiple of $0.50 (but not of $1), it will be rounded to the next higher $1.

(2) Before November 2 of each calendar year after 1978, the Commissioner will publish in the FEDERAL REGISTER the formula and updated dollar amounts to be used for determining the monthly maximum for the following year.

(d–1) *Entitled to disability insurance benefits after June 1980.* If you first become eligible for old-age or disability insurance benefits after 1978 and first entitled to disability insurance benefits after June 1980, we compute the monthly family maximum under a formula which is different from that in paragraphs (c) and (d) of this section. The computation under the new formula is as follows:

(1) We take 85 percent of your average indexed monthly earnings and compare that figure with your primary insurance amount (see § 404.212 of this part). We work with the larger of these two amounts.

(2) We take 150 percent of your primary insurance amount.

(3) We compare the results of paragraphs (d–1) (1) and (2) of this section. The smaller amount is the monthly family maximum. As a result of this rule, the entitled spouse and children of some workers will not be paid any benefits because the family maximum does not exceed the primary insurance amount.

(e) *Person entitled on more than one record during years after 1978 and before 1984.* (1) If any of the persons entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable may not be reduced to less than the smaller of—(i) the sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or (ii) 1.75 times the highest primary insurance amount possible for that month based on the average indexed monthly earnings equal to one-twelfth of the contribution and benefit base determined for that year.

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the others was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (e)(1) of this section.

(f) *Person entitled on more than one record for years after 1983.* (1) If any person for whom paragraphs (c) and (d) would apply is entitled to monthly benefits on the earnings record of an insured individual would, except for the limitation described in § 404.353(b), be entitled to child's insurance benefits on the earnings record of one or more other insured individuals, the total benefits payable to all persons on the earnings record of any of those insured individuals may not be reduced to less than the smaller of:

(i) The sum of the maximum amounts of benefits payable on the earnings records of all the insured individuals, or

(ii) 1.75 times the highest primary insurance amount possible for January 1983, or if later, January of the year that the person becomes entitled or reentitled on more than one record.

This highest primary insurance amount possible for that year will be based on the average indexed monthly earnings equal to one-twelfth of the

contribution and benefit base determined for that year. Thereafter, the total monthly benefits payable to persons on the earnings record of those insured individuals will then be increased only when monthly benefits are increased because of cost-of-living adjustments (see § 404.270ff).

(2) If benefits are payable on the earnings of more than one individual and the primary insurance amount of one of the insured individuals was computed under the provisions in effect before 1979 and the primary insurance amount of the other was computed under the provisions in effect after 1978, the maximum monthly benefits cannot be more than the amount computed under paragraph (f)(1) of this section.

(g) *Person previously entitled to disability insurance benefits.* If an insured individual who was previously entitled to disability insurance benefits becomes entitled to a ''second entitlement'' as defined in § 404.250, or dies, after 1995, and the insured individual's primary insurance amount is determined under §§ 404.251(a)(1), 404.251(b)(1), or 404.252(b), the monthly maximum during the second entitlement is determined under the following rules:

(1) If the primary insurance amount is determined under §§ 404.251(a)(1) or 404.251(b)(1), the monthly maximum equals the maximum in the last month of the insured individual's earlier entitlement to disability benefits, increased by any cost-of-living or ad hoc increases since then.

(2) If the primary insurance amount is determined under § 404.252(b), the monthly maximum equals the maximum in the last month of the insured individual's earlier entitlement to disability benefits.

(3) Notwithstanding paragraphs (g)(1) and (g)(2) of this section, if the second entitlement is due to the insured individual's retirement or death, and the monthly maximum in the last month of the insured individual's earlier entitlement to disability benefits was computed under paragraph (d–1) of this section, the monthly maximum is equal to the maximum that would have been determined for the last month of such earlier entitlement if computed without regard for paragraph (d–1) of this section.

[45 FR 1611, Jan. 8, 1980, as amended at 46 FR 25601, May 8, 1981; 48 FR 46148, Oct. 11, 1983; 51 FR 12606, Apr. 14, 1986; 58 FR 64892, Dec. 10, 1993; 62 FR 38450, July 18, 1997; 64 FR 17101, Apr. 8, 1999; 64 FR 57775, Oct. 27, 1999; 65 FR 16813, Mar. 30, 2000]

§ 404.404 How reduction for maximum affects insured individual and other persons entitled on his earnings record.

If a reduction of monthly benefits is required under the provisions of § 404.403, the monthly benefit amount of each of the persons entitled to a monthly benefits on the same earnings record (with the exception of the individual entitled to old-age or disability insurance benefits) is proportionately reduced so that the total benefits that can be paid in 1 month (including an amount equal to the primary insurance amount of the old-age or disability insurance beneficiary, when applicable) does not exceed the maximum family benefit (except as provided in § 404.405 where various savings clause provisions are described).

§ 404.405 Situations where total benefits can exceed maximum because of "savings clause."

The following provisions are *savings clauses* and describe exceptions to the rules concerning the maximum amount payable on an individual's earnings record in a month as described in § 404.403. The effect of a *savings clause* is to avoid lowering benefit amounts or to guarantee minimum increases to certain persons entitled on the earnings record of the insured individual when a statutory change has been made that would otherwise disadvantage them. The reduction described in § 404.403 does not apply in the following instances:

(a)–(m) [Reserved]

(n) *Months after August 1972.* The reduction described in § 404.403(a) shall not apply to benefits for months after August 1972 where two or more persons were entitled to benefits for August 1972 based upon the filing of an application in August 1972 or earlier and the total of such benefits was subject to reduction for the maximum under § 404.403 (or would have been subject to

such reduction except for this paragraph) for January 1971. In such a case, maximum family benefits on the insured individual's earnings record for any month after August 1972 may not be less than the larger of:

(1) The maximum family benefits for such month determined under the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The total obtained by multiplying each benefit for August 1972 after reduction for the maximum but before deduction or reduction for age, by 120 percent and raising each such increased amount, if it is not a multiple of 10 cents, to the next higher multiple of 10 cents.

(o) *Months after December 1972.* The reduction described in § 404.403 shall not apply to benefits for months after December 1972 in the following cases:

(1) In the case of a redetermination of widow's or widower's benefits, the reduction described in § 404.403 shall not apply if:

(i) Two or more persons were entitled to benefits for December 1972 on the earnings records of a deceased individual and at least one such person is entitled to benefits as the deceased individual's widow or widower for December 1972 and for January 1973; and

(ii) The total of benefits to which all persons are entitled for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(1)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the widow's or widower's benefit had not been redetermined under the Social Security Amendments of 1972.

(2) In the case of entitlement to child's benefits based upon disability which began between ages 18 and 22 the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in that month or earlier; and

(ii) One or more persons not included in paragraph (o)(2)(i) of this section are entitled to child's benefits on that earnings record for January 1973 based upon disability which began in the period from ages 18 to 22; and

(iii) The total benefits to which all persons are entitled on that record for January 1973 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each person referred to in paragraph (o)(2)(i) of this section for months after December 1972 shall be no less than the amount it would have been if the person entitled to child's benefits based upon disability in the period from ages 18 to 22 were not so entitled.

(3) In the case of entitlement of certain surviving divorced mothers, the reduction described in § 404.403 shall not apply if:

(i) One or more persons were entitled to benefits on the insured individual's earnings record for December 1972 based upon an application filed in December 1972 or earlier; and

(ii) One or more persons not included in paragraph (o)(3)(i) of this section are entitled to benefits on that earnings record as a surviving divorced mother for a month after December 1972; and

(iii) The total of benefits to which all persons are entitled on that record for any month after December 1972 is reduced (or would be reduced if deductions were not applicable) for the maximum under § 404.403.

In such case, the benefit of each such person referred to in paragraph (o)(3)(i) of this section for months after December 1972 in which any person referred to in paragraph (o)(3)(ii) of this section is entitled shall be no less than it would have been if the person(s) referred to in paragraph (o)(3)(ii) of this section had not become entitled to benefits.

(p) *Months after December 1973.* The reduction described in § 404.403 shall not apply to benefits for months after December 1973 where two or more persons were entitled to monthly benefits for January 1971 or earlier based upon applications filed in January 1971 or earlier, and the total of such benefits was subject to reduction for the maximum

under § 404.403 for January 1971 or earlier. In such a case, maximum family benefits payable on the insured individual's earnings record for any month after January 1971 may not be less than the larger of:

(1) The maximum family benefit for such month shown in the applicable table in section 215(a) of the Act (the *applicable* table in section 215(a) of the Act is that table which is effective for the month the benefit is payable or in the case of a lump-sum payment, the month the individual died); or

(2) The largest amount which has been determined payable for any month for persons entitled to benefits on the insured individual's earnings records; or

(3) In the case of persons entitled to benefits on the insured individual's earnings record for the month immediately preceding the month of a general benefit or cost-of-living increase after September 1972, an amount equal to the sum of the benefit amount for each person (excluding any part of an old-age insurance benefit increased because of delayed retirement under the provisions of § 404.305(a) for the month immediately before the month of increase in the primary insurance amount (after reduction for the family maximum but before deductions or reductions for age) multiplied by the percentage of increase. Any such increased amount, if it is not a multiple of $0.10, will be raised to the next higher multiple of $0.10 for months before June 1982 and reduced to the next lower multiple of $0.10 for months after May 1982.

(q) *Months after May 1978.* The *family maximum* for months after May 1978 is figured for all beneficiaries just as it would have been if none of them had gotten a benefit increase because of the retirement credit if:

(1) One or more persons were entitled (without the reduction required by § 404.406) to monthly benefits for May 1978 on the wages and self-employment income of a deceased wage earner;

(2) The benefit for June 1978 of at least one of those persons is increased by reason of a delayed retirement credit (see § 404.330(b)(4) or § 404.333(b)(4)); and

(3) The total amount of monthly benefits to which all those persons are entitled is reduced because of the maximum or would be so reduced except for certain restrictions (see § 404.403 and § 404.402(a)).

[32 FR 19159, Dec. 20, 1967, as amended at 40 FR 30814, July 23, 1975; 43 FR 8132, Feb. 28, 1978; 43 FR 29277, July 7, 1978; 48 FR 46148, Oct. 11, 1983]

§ 404.406 Reduction for maximum because of retroactive effect of application for monthly benefits.

Under the provisions described in § 404.403, beginning with the month in which a person files an application and becomes entitled to benefits on an insured individual's earnings record, the benefit rate of other persons entitled on the same earnings record (aside from the individual on whose earnings record entitlement is based) are adjusted downward, if necessary, so that the maximum benefits payable on one earnings record will not be exceeded. An application may also be effective (retroactively) for benefits for months before the month of filing (see § 404.603). For any month before the month of filing, however, benefits that have been previously certified by the Administration for payment to other persons (on the same earnings record) are not changed. Rather, the benefit payment of the person filing the application in the later month is reduced for each month of the retroactive period to the extent that may be necessary, so that no earlier payment to some other person is made erroneous. This means that for each month of the retroactive period the amount payable to the person filing the later application is the difference, if any, between (a) the total amount of benefits actually certified for payment to other persons for that month, and (b) the maximum amount of benefits payable for that month to all persons, including the person filing later.

[32 FR 19159, Dec. 20, 1967, as amended at 64 FR 14608, Mar. 26, 1999]

§ 404.407 Reduction because of entitlement to other benefits.

(a) *Entitlement to old-age or disability insurance benefit and other monthly benefit.* If an individual is entitled to an old-age insurance benefit or disability insurance benefit for any month after

August 1958 and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D of this part) for the same month, such other benefit for the month, after any reduction under section 202(q) of the Act because of entitlement to such benefit for months before retirement age and any reduction under section 203(a) of the Act, is reduced (but not below zero) by an amount equal to such old-age insurance benefit (after reduction under section 202(q) of the Act) or such disability insurance benefit, as the case may be.

(b) *Entitlement to widow's or widower's benefit and other monthly benefit.* If an individual is entitled for any month after August 1965 to a widow's or widower's insurance benefit under the provisions of section 202 (e)(4) or (f)(5) of the Act and to any other monthly benefit payable under the provisions of title II of the Act (see subpart D) for the same month, except an old-age insurance benefit, such other insurance benefit for that month, after any reduction under paragraph (a) of this section, any reduction for age under section 202(q) of the Act, and any reduction under the provisions described in section 203(a) of the Act, shall be reduced, but not below zero, by an amount equal to such widow's or widower's insurance benefit after any reduction or reductions under paragraph (a) of this section or section 203(a) of the Act.

(c) *Entitlement to old-age insurance benefit and disability insurance benefit.* Any individual who is entitled for any month after August 1965 to both an old-age insurance benefit and a disability insurance benefit shall be entitled to only the larger of such benefits for such month, except that where the individual so elects, he or she shall instead be entitled to only the smaller of such benefits for such month. Only a person defined in § 404.612 (a), (c), or (d) may make the above described election.

(d) *Child's insurance benefits.* A child may, for any month, be simultaneously entitled to a child's insurance benefit on more than one individual's earnings if all the conditions for entitlement described in § 404.350 are met with respect to each claim. Where a child is simultaneously entitled to child's insurance benefits on more than one earnings record, the general rule is that the child will be paid an amount which is based on the record having the highest primary insurance amount. However, the child will be paid a higher amount which is based on the earnings record having a lower primary insurance amount if no other beneficiary entitled on any record would receive a lower benefit because the child is paid on the record with the lower primary insurance amount. (See § 404.353(b).)

(e) *Entitlement to more than one benefit where not all benefits are child's insurance benefits and no benefit is an old-age or disability insurance benefit.* If an individual (other than an individual to whom section 202 (e)(4) or (f)(5) of the Act applies) is entitled for any month to more than one monthly benefit payable under the provisions of this subpart, none of which is an old-age or disability insurance benefit and all of which are not child's insurance benefits, only the greater of the monthly benefits to which he would (but for the provisions of this paragraph) otherwise be entitled is payable for such month. For months after August 1965, an individual who is entitled for any month to more than one widow's or widower's insurance benefit to which section 202 (e)(4) or (f)(5) of the Act applies is entitled to only one such benefit for such month, such benefit to be the largest of such benefits.

[32 FR 19159, Dec. 20, 1967, as amended at 51 FR 12606, Apr. 14, 1986; 54 FR 5603, Feb. 6, 1989]

§ 404.408 Reduction of benefits based on disability on account of receipt of certain other disability benefits provided under Federal, State, or local laws or plans.

(a) *When reduction required.* Under section 224 of the Act, a disability insurance benefit to which an individual is entitled under section 223 of the Act for a month (and any monthly benefit for the same month payable to others under section 202 on the basis of the same earnings record) is reduced (except as provided in paragraph (b) of this section) by an amount determined under paragraph (c) of this section if:

(1) The individual first became entitled to disability insurance benefits after 1965 but before September 1981 based on a period of disability that began after June 1, 1965, and before March 1981, and

(i) The individual entitled to the disability insurance benefit is also entitled to periodic benefits under a workers' compensation law or plan of the United States or a State for that month for a total or partial disability (whether or not permanent), and

(ii) The Commissioner has, in a month before that month, received a notice of the entitlement, and

(iii) The individual has not attained age 62, or

(2) The individual first became entitled to disability insurance benefits after August 1981 based on a disability that began after February 1981, and

(i) The individual entitled to the disability insurance benefit is also, for that month, concurrently entitled to a periodic benefit (including workers' compensation or any other payments based on a work relationship) on account of a total or partial disability (whether or not permanent) under a law or plan of the United States, a State, a political subdivision, or an instrumentality of two or more of these entities, and

(ii) The individual has not attained age 65.

(b) *When reduction not made.* (1) The reduction of a benefit otherwise required by paragraph (a)(1) of this section is not made if the workers' compensation law or plan under which the periodic benefit is payable provides for the reduction of such periodic benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act.

(2) The reduction of a benefit otherwise required by paragraph (a)(2) of this section is not to be made if:

(i) The law or plan under which the periodic public disability benefit is payable provides for the reduction of that benefit when anyone is entitled to a benefit under title II of the Act on the basis of the earnings record of an individual entitled to a disability insurance benefit under section 223 of the Act and that law or plan so provided on February 18, 1981. (The reduction required by paragraph (a)(2) of this section will not be affected by public disability reduction provisions not actually in effect on this date or by changes made after February 18, 1981, to provisions that were in effect on this date providing for the reduction of benefits previously not subject to a reduction); or

(ii) The benefit is a Veterans Administration benefit, a public disability benefit (except workers' compensation) payable to a public employee based on employment covered under Social Security, a public benefit based on need, or a wholly private pension or private insurance benefit.

(c) *Amount of reduction*—(1) *General.* The total of benefits payable for a month under sections 223 and 202 of the Act to which paragraph (a) of this section applies is reduced monthly (but not below zero) by the amount by which the sum of the monthly disability insurance benefits payable on the disabled individual's earnings record and the other public disability benefits payable for that month exceeds the higher of:

(i) Eighty percent of his *average current earnings,* as defined in paragraph (c)(3) of this section, or

(ii) The total of such individual's disability insurance benefit for such month and all other benefits payable for such month based on such individual's earnings record, prior to reduction under this section.

(2) *Limitation on reduction.* In no case may the total of monthly benefits payable for a month to the disabled worker and to the persons entitled to benefits for such month on his earnings record be less than:

(i) The total of the benefits payable (after reduction under paragraph (a) of this section) to such beneficiaries for the first month for which reduction under this section is made, and

(ii) Any increase in such benefits which is made effective for months after the first month for which reduction under this section is made.

(3) *Average current earnings defined.* (i) Beginning January 1, 1979, for purposes of this section, an individual's *average current earnings* is the largest of either

paragraph (c)(3)(i) (*a*), (*b*) or (*c*) of this section (after reducing the amount to the next lower multiple of $1 when the amount is not a multiple of $1):

(A) The average monthly wage (determined under section 215(b) of the Act as in effect prior to January 1979) used for purposes of computing the individual's disability insurance benefit under section 223 of the Act;

(B) One-sixtieth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the 5 consecutive calendar years after 1950 for which the wages and earnings from self-employment were highest; or

(C) One-twelfth of the total of the individual's wages and earnings from self-employment, without the limitations under sections 209(a) and 211(b)(1) of the Act (see paragraph (c)(3)(ii) of this section), for the calendar year in which the individual had the highest wages and earnings from self-employment during the period consisting of the calendar year in which the individual became disabled and the 5 years immediately preceding that year. Any amount so computed which is not a multiple of $1 is reduced to the next lower multiple of $1.

(ii) *Method of determining calendar year earnings in excess of the limitations under sections 209(a) and 211(b)(1) of the Act.* For the purposes of paragraph (c)(3)(i) of this section, the extent by which the wages or earnings from self-employment of an individual exceed the maximum amount of earnings creditable under sections 209(a) and 211(b)(1) of the Act in any calendar year after 1950 and before 1978 will ordinarily be estimated on the basis of the earnings information available in the records of Administration. (See subpart I of this part.) If an individual provides satisfactory evidence of his actual earnings in any year, the extent, if any, by which his earnings exceed the limitations under sections 209(a) and 211(b)(1) of the Act shall be determined by the use of such evidence instead of by the use of estimates.

(4) *Reentitlement to disability insurance benefits.* If an individual's entitlement to disability insurance benefits terminates and such individual again becomes entitled to disability insurance benefits, the amount of the reduction is again computed based on the figures specified in this paragraph (c) applicable to the subsequent entitlement.

(5) *Computing disability insurance benefits.* When reduction is required, the total monthly Social Security disability insurance benefits payable after reduction can be more easily computed by subtracting the monthly amount of the other public disability benefit from the higher of paragraph (c)(1) (i) or (ii). This is the method employed in the examples used in this section.

(d) *Items not counted for reduction.* Amounts paid or incurred, or to be incurred, by the individual for medical, legal, or related expenses in connection with the claim for public disability payments (see § 404.408 (a) and (b)) or the injury or occupational disease on which the public disability award or settlement agreement is based, are excluded in computing the reduction under paragraph (a) of this section to the extent they are consonant with the applicable Federal, State, or local law or plan and reflect either the actual amount of expenses already incurred or a reasonable estimate, given the circumstances in the individual's case, of future expenses. Any expenses not established by evidence required by the Administration or not reflecting a reasonable estimate of the individual's actual future expenses will not be excluded. These medical, legal, or related expenses may be evidenced by the public disability award, compromise agreement, a court order, or by other evidence as the Administration may require. This other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other clear and convincing evidence indicating the amount of expenses; or

(4) Any combination of the foregoing evidence from which the amount of expenses may be determinable.

(e) *Certification by individual concerning eligibility for public disability*

benefits. Where it appears that an individual may be eligible for a public disability benefit which would give rise to a reduction under paragraph (a) of this section, the individual may be required, as a condition of certification for payment of any benefit under section 223 of the Act to any individual for any month, and of any benefit under section 202 of the Act for any month based on such individual's earnings record, to furnish evidence as requested by the Administration and to certify as to:

(1) Whether he or she has filed or intends to file any claim for a public disability benefit, and

(2) If he or she has so filed, whether there has been a decision on the claim. The Commissioner may rely, in the absence of evidence to the contrary, upon a certification that he or she has not filed and does not intend to file such a claim, or that he or she has filed and no decision has been made, in certifying any benefit for payment pursuant to section 205(i) of the Act.

(f) *Verification of eligibility or entitlement to a public disability benefit under paragraph (a).* Section 224 of the Act requires the head of any Federal agency to furnish the Commissioner information from the Federal agency's records which is needed to determine the reduction amount, if any, or verify other information to carry out the provisions of this section. The Commissioner is authorized to enter into agreements with States, political subdivisions, and other organizations that administer a law or plan of public disability benefits in order to obtain information that may be required to carry out the provisions of this section.

(g) *Public disability benefit payable on other than a monthly basis.* Where public disability benefits are paid periodically but not monthly, or in a lump sum as a commutation of or a substitute for periodic benefits, such as a compromise and release settlement, the reduction under this section is made at the time or times and in the amounts that the Administration determines will approximate as nearly as practicable the reduction required under paragraph (a) of this section.

(h) *Priorities.* (1) For an explanation of when a reduction is made under this section where other reductions, deductions, etc., are involved, see § 404.402.

(2) Whenever a reduction in the total of benefits for any month based on an individual's earnings record is made under paragraph (a) of this section, each benefit, except the disability insurance benefit, is first proportionately decreased. Any excess reduction over the sum of all the benefits, other than the disability insurance benefit, is then applied to the disability insurance benefit.

Example 1: Effective September 1981, Harold is entitled to a monthly disability primary insurance amount of $507.90 and a monthly public disability benefit of $410.00 from the State. Eighty percent of Harold's average current earnings is $800.00. Because this amount ($800.00) is higher than Harold's disability insurance benefit ($507.90), we subtract Harold's monthly public disability benefit ($410.00) from eighty percent of his average current earnings ($800.00). This leaves Harold a reduced monthly disability benefit of $390.00.

Example 2: In September 1981, Tom is entitled to a monthly disability primary insurance amount of $559.30. His wife and two children are also entitled to monthly benefits of $93.20 each. The total family benefit is $838.90. Tom is also receiving a monthly workers' compensation benefit of $500.00 from the State. Eighty percent of Tom's average current earnings is $820.10. Because the total family benefit ($838.90) is higher than 80 percent of the average current earnings ($820.10), we subtract the monthly workers' compensation benefit ($500.00) from the total family benefit ($838.90), leaving $338.90 payable. This means the monthly benefits to Tom's wife and children are reduced to zero, and Tom's monthly disability benefit is reduced to $338.90.

(i) *Effect of changes in family composition.* The addition or subtraction in the number of beneficiaries in a family may cause the family benefit to become, or cease to be, the applicable limit for reduction purposes under this section. When the family composition changes, the amount of the reduction is recalculated as though the new number of beneficiaries were entitled for the first month the reduction was imposed. If the applicable limit both before and after the change is 80 percent of the average current earnings and the limitation on maximum family benefits is in effect both before and after

the change, the amount payable remains the same and is simply redistributed among the beneficiaries entitled on the same earnings record.

Example 1: Frank is receiving $500.00 a month under the provisions of a State workers' compensation law. He had a prior period of disability which terminated in June 1978. In September 1981, Frank applies for a second period of disability and is awarded monthly disability insurance benefits with a primary insurance amount of $370.20. His child, Doug, qualifies for benefits of $135.10 a month on Frank's earnings record. The total family benefits is $505.30 monthly.

Frank's average monthly wage (as used to compute the primary insurance amount) is $400.00; eighty percent of his average current earnings (computed by using the 5 consecutive years in which his earnings were highest) is $428.80 (80% of $536.00); eighty percent of Frank's average current earnings (computed by using the 1 calendar year in which his earnings were highest) is $509.60 (80% of $637.00). The highest value for 80 percent of average current earnings is therefore $509.60 (80%). Since this is higher than the total family benefit ($505.30), the $509.60 is the applicable limit in determining the amount of the reduction (or offset). The amount payable after the reduction is—

80% of Frank's average current earnings	$509.60
Frank's monthly workers' compensation benefit	−500.00
Monthly benefit payable to Frank	9.60

No monthly benefits are payable to Doug because the reduction is applied to Doug's benefit first. In December 1981, another child, Mike, becomes entitled on Frank's earnings record. The monthly benefit to each child before reduction is now $109.10, the amount payable when there are two beneficiaries in addition to the wage earner. Thus, the total family benefit becomes $588.40. Because this is now higher than $509.60 (80% of Frank's average current earnings), $588.40 becomes the applicable limit in determining the amount of reduction. The amount payable after the increase in the total family benefit is—

The new total family benefit	$588.40
Frank's monthly workers' compensation rate	−500.00
Monthly benefit payable to Frank	88.40

No monthly benefits are payable to either child because the reduction (or offset) is applied to the family benefits first.

Example 2: Jack became entitled to disability insurance benefits in December 1973 (12/73), with a primary insurance amount (PIA) of $220.40. He was also receiving a workers' compensation benefit. An offset was imposed against the disability insurance benefit. By June 1977 (6/77), Jack's PIA had increased to $298.00 because of several statutory benefit increases. In December 1977 (12/77), his wife, Helen, attained age 65 and filed for unreduced wife's benefits. (She was not entitled to a benefit on her own earnings record.) This benefit was terminated in May 1978 (5/78), at her death. Helen's benefit was computed back to 12/73 as though she were entitled in the first month that offset was imposed against Jack. Since there were no other beneficiaries entitled and Helen's entire monthly benefit amount is subject to offset, the benefit payable to her for 12/77 through April 1978 (4/78), would be $38.80. This gives Helen the protected statutory benefit increases since 12/73. The table below shows how Helen's benefit was computed beginning with the first month offset was imposed.

Month of entitlement/ statutory increase	Jack's PIA	Helen's benefit prior to offset	Helen's statutory increase
December 1973	$220.40	$110.20	.....
March 1974	236.00	118.00	$7.80
June 1974	244.80	122.40	+4.40
June 1975	264.40	132.20	+9.80
June 1976	281.40	140.70	+8.50
June 1977	298.00	149.00	+8.30
December 1977 through April 1978[1]	.....	.....	38.80

[1] Monthly benefit payable to Helen.

(j) *Effect of social security disability insurance benefit increases.* Any increase in benefits due to a recomputation or a statutory increase in benefit rates is not subject to the reduction for public disability benefits under paragraph (a) and does not change the amount to be deducted from the family benefit. The increase is simply added to what amount, if any, is payable. If a new beneficiary becomes entitled to monthly benefits on the same earnings record after the increase, the amount of the reduction is redistributed among the new beneficiaries entitled under section 202 of the Act and deducted from their current benefit rate.

Example: In March 1981, Chuck became entitled to disability insurance benefits with a primary insurance amount of $362.40 a month. He has a wife and two children who are each entitled to a monthly benefit of $60.40. Chuck is receiving monthly disability compensation from a worker's compensation plan of $410.00. Eighty percent of his average current earnings is $800.00. Because this is higher than the total family benefit ($543.60), $800.00 is the applicable limit in computing the amount of reduction. The amount of

monthly benefits payable after the reduction is—

Applicable limit	$800.00
Chuck's monthly disability compensation	−410.00
Total amount payable to Chuck and the family after reduction	$390.00
Amount payable to Chuck	−362.40
Total amount payable to the family	$27.60
$9.20 payable to each family member equals	$27.60
	3

In June 1981, the disability benefit rates were raised to reflect an increase in the cost-of-living. Chuck is now entitled to $403.00 a month and each family member is entitled to $67.20 a month (an increase of $6.80 to each family member). The monthly amounts payable after the cost-of-living increase are now $403.00 to Chuck and $16.00 to each family member ($9.20 plus the $6.80 increase).

In September 1981, another child becomes entitled to benefits based on Chuck's earnings record. The monthly amount payable to the family (excluding Chuck) must now be divided by 4:

$6.90 payable to each family member equals	$27.60
	4

The June 1981 cost-of-living increase is added to determine the amount payable. Chuck continues to receive $403.00 monthly. Each family member receives a cost-of-living increase of $5.10. Thus, the amount payable to each is $12.00 in September 1981 ($6.90 plus the $5.10 increase). (See Example 2 under (i).)

(k) *Effect of changes in the amount of the public disability benefit.* Any change in the amount of the public disability benefit received will result in a recalculation of the reduction under paragraph (a) and, potentially, an adjustment in the amount of such reduction. If the reduction is made under paragraph (a)(1) of this section, any increased reduction will be imposed effective with the month after the month the Commissioner received notice of the increase in the public disability benefit (it should be noted that only workers' compensation can cause this reduction). Adjustments due to a decrease in the amount of the public disability benefit will be effective with the actual date the decreased amount was effective. If the reduction is made under paragraph (a)(2) of this section, any increase or decrease in the reduction will be imposed effective with the actual date of entitlement to the new amount of the public disability benefit.

Example: In September 1981, based on a disability which began March 12, 1981, Theresa became entitled to Social Security disability insurance benefits with a primary insurance amount of $445.70 a month. She had previously been entitled to Social Security disability insurance benefits from March 1967 through July 1969. She is receiving a temporary total workers' compensation payment of $227.50 a month. Eighty percent of her average current earnings is $610.50. The amount of monthly disability insurance benefit payable after reduction is—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment	−227.50
Total amount payable to Theresa after reduction	383.00

On November 15, 1981, the Commissioner was notified that Theresa's workers' compensation rate was increased to $303.30 a month effective October 1, 1981. This increase reflected a cost-of-living adjustment granted to all workers' compensation recipients in her State. The reduction to her monthly disability insurance benefit is recomputed to take this increase into account—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning October 1, 1981	−303.30
Total new amount payable to Theresa beginning October 1981 after recalculation of the reduction	$307.20

Effective January, 1, 1982, Theresa's workers' compensation payment is decreased to $280.10 a month when she begins to receive a permanent partial payment. The reduction to her monthly disability insurance benefit is again recalculated to reflect her decreased workers' compensation amount—

80 percent of Theresa's average current earnings	$610.50
Theresa's monthly workers' compensation payment beginning January 1, 1982	−280.10
Total new amount payable to Theresa beginning January 1982 after recalculation of the reduction	$330.40

If, in the above example, Theresa had become entitled to disability insurance benefits in August 1981, the increased reduction to her benefit, due to the October 1, 1981 increase in her workers' compensation payment, would have been imposed beginning with December 1981, the month after the month she notified the Social Security Administration of the increase. The later decrease in her workers' compensation payment would still affect her disability insurance benefit beginning with January 1982.

(l) *Redetermination of benefits*—(1) *General.* In the second calendar year after the year in which reduction under

this section in the total of an individual's benefits under section 223 of the Act and any benefits under section 202 of the Act based on his or her wages and self-employment income is first required (in a continuous period of months), and in each third year thereafter, the amount of those benefits which are still subject to reduction under this section are redetermined, provided this redetermination does not result in any decrease in the total amount of benefits payable under title II of the Act on the basis of the workers' wages and self-employment income. The redetermined benefit is effective with the January following the year in which the redetermination is made.

(2) *Average current earnings.* In making the redetermination required by paragraph (l)(1) of this section, the individual's average current earnings (as defined in paragraph (c)(3) of this section) is deemed to be the product of his average current earnings as initially determined under paragraph (c)(3) of this section and:

(i) The ratio of the average of the total wages (as defined in § 404.1049) of all persons for whom wages were reported to the Secretary of the Treasury or his delegate for the calendar year before the year in which the redetermination is made, to the average of the total wages of all person reported to the Secretary of the Treasury or his delegate for calendar year 1977 or, if later, the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability); and

(ii) In any case in which the reduction was first computed before 1978, the ratio of the average of the taxable wages reported to the Commissioner of Social Security for the first calendar quarter of 1977 to the average of the taxable wages reported to the Commissioner of Social Security for the first calendar quarter of the calendar year before the year in which the reduction was first computed (but not counting any reduction made in benefits for a previous period of disability). Any amount determined under the preceding two sentences which is not a multiple of $1 is reduced to the next lower multiple of $1.

(3) *Effect of redetermination.* Where the applicable limit on total benefits previously used was 80 percent of the average current earnings, a redetermination under this paragraph may cause an increase in the amount of benefits payable. Also, where the limit previously used was the total family benefit, the redetermination may cause the average current earnings to exceed the total family benefit and thus become the new applicable limit. If for some other reason (such as a statutory increase or recomputation) the benefit has already been increased to a level which equals or exceeds the benefit resulting from a redetermination under this paragraph, no additional increase is made. A redetermination is designed to bring benefits into line with current wage levels when no other change in payments has done so.

Example: In October 1978, Alice became entitled to disability insurance benefits with a primary insurance amount of $505.10. Her two children were also entitled to monthly benefits of $189.40 each. Alice was also entitled to monthly disability compensation benefits of $667.30 from the State. Eighty percent of Alice's average current earnings is $1340.80, and that amount is the applicable limit. The amount of monthly benefits payable after the reduction is—

Applicable limit	$1,340.80
Alice's State disability compensation benefit	−667.30
Total benefits payable to Alice and both children after reduction	$673.50
Alice's disability insurance benefit	−505.10
Payable to the children	$168.40
$84.20 payable to each child after reduction equals	$168.40
	2

In June 1979 and June 1980, cost-of-living increases in Social Security benefits raise Alice's benefit by $50.10 (to $555.20) and $79.40 (to $634.60) respectively. The children's benefits (before reduction) are each raised by $18.80 (to $208.20) and $29.80 (to $238.00). These increases in Social Security benefits are not subject to the reduction (i.e., offset).

In 1980, Alice's average current earnings are redetermined as required by law. The offset is recalculated, and if the amount payable to the family is higher than the current amount payable to the family, that higher amount becomes payable the following January (i.e., January 1981). The current amount payable to the family after the reduction is recalculated—

Alice's 1978 benefit after reduction	$505.10
Alice's cost-of-living increase in June 1979	+50.10
Alice's cost-of-living increase in June 1980	+79.40
One child's 1978 benefit after reduction	+84.20
That child's cost-of-living increase in June 1979	+18.70
That child's cost-of-living increase in June 1980	+29.70
The other child's 1978 benefit after reduction	+84.20
The other child's cost-of-living increase in June 1979	+18.70
The other child's cost-of-living increase in June 1980	+29.70
Total amount payable to the family after reduction in January 1981	899.80

The amount payable to the family after reduction is then recalculated using the redetermined average current earnings—

Average current earnings before redetermination	$1,676.00
Redetermination ratio effective for January 1981	×1.174
Redetermined average current earnings	$1,967.00
	×80%
80% of the redetermined average current earnings	$1,573.60
Alice's State disability compensation benefit	−667.30
Total benefits payable to the family after offset	$906.30

We then compare the total amount currently being paid to the family ($899.80) to the total amount payable after the redetermination ($906.30). In this example, the redetermination yields a higher amount and, therefore, becomes payable the following January (i.e., January 1981). Additional computations are required to determine the amount that will be paid to each family member—

Total benefits payable to the family using the redetermined average current earnings	$906.30
Total cost-of-living increases to both children	−96.80
Balance payable	809.50
Alice's current benefit amount before reduction	−634.60
Payable to the children	174.90
Total cost-of-living increases to both children	+96.80
Total payable to children after reduction	271.70
$135.90 (rounded from $135.85) payable to each child equals	$271.70
	2

[32 FR 19159, Dec. 20, 1967; 33 FR 3060, Feb. 16, 1968, as amended at 37 FR 3425, Feb. 16, 1972; 48 FR 37017, Aug. 16, 1983; 48 FR 38814, Aug. 26, 1983; 62 FR 38450, July 18, 1997]

§ 404.408a Reduction where spouse is receiving a Government pension.

(a) *When reduction is required.* Unless you meet one of the exceptions in paragraph (b) of this section, your monthly Social Security benefits as a wife, husband, widow, widower, mother, or father will be reduced each month you are receiving a monthly pension from a Federal, State, or local government agency (Government pension) for which you were employed in work not covered by Social Security on the last day of such employment. Your monthly Social Security benefit as a spouse will always be reduced because of your Government pension even if you afterwards return to work for a government agency and that work is covered by Social Security. For purposes of this section, Federal Government employees are not considered to be covered by Social Security if they are covered for Medicare but are not otherwise covered by Social Security. If the government pension is not paid monthly or is paid in a lump-sum, we will determine how much the pension would be if it were paid monthly and then reduce the monthly Social Security benefit accordingly. The number of years covered by a lump-sum payment, and thus the period when the Social Security benefit will be reduced, will generally be clear from the pension plan. If one of the alternatives to a lump-sum payment is a life annuity, and the amount of the monthly benefit for the life annuity can be determined, the reduction will be based on that monthly benefit amount. Where the period or the equivalent monthly pension benefit is not clear it may be necessary for us to determine the reduction period on an individual basis.

(b) *Exceptions.* The reduction does not apply:

(1) If you are receiving a Government pension based on employment for an interstate instrumentality.

(2) If you received or are eligible to receive a Government pension for one or more months in the period December 1977 through November 1982 and you meet the requirements for Social Security benefits that were applied in January 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving

benefits until a later month. The January 1977 requirements are, for a man, a one-half support test (see paragraph (c) of this section), and, for a woman claiming benefits as a divorced spouse, marriage for at least 20 years to the insured worker. You are considered eligible for a Government pension for any month in which you meet all the requirements for payment except that you are working or have not applied.

(3) If you were receiving or were eligible (as defined in paragraph (b)(2) of this section) to receive a Government pension for one or more months before July 1983, and you meet the dependency test of one-half support that was applied to claimants for husband's and widower's benefits in 1977, even though you don't claim benefits, and you don't actually meet the requirements for receiving benefits until a later month. If you meet the exception in this paragraph but you do not meet the exception in paragraph (b)(2), December 1982 is the earliest month for which the reduction will not affect your benefits.

(4) If you would have been eligible for a pension in a given month except for a requirement which delayed eligibility for such pension until the month following the month in which all other requirements were met, we will consider you to be eligible in that given month for the purpose of meeting one of the exceptions in paragraphs (b) (2) and (3) of this section. If you meet an exception solely because of this provision, your benefits will be unreduced for months after November 1984 only.

(5) If, with respect to monthly benefits payable for months after December 1994, you are receiving a Government pension based wholly upon service as a member of a uniformed service, regardless of whether on active or inactive duty and whether covered by social security. However, if the earnings on the last day of employment as a military reservist were not covered, January 1995 is the earliest month for which the reduction will not affect your benefits.

(c) The *one-half support test.* For a man to meet the January 1977 requirement as provided in the exception in paragraph (b)(2) and for a man or a woman to meet the exception in paragraph (b)(3) of this section, he or she must meet a one-half support test. One-half support is defined in §404.366 of this part. One-half support must be met at one of the following times:

(1) If the insured person had a period of disability which did not end before he or she became entitled to old-age or disability insurance benefits, or died, you must have been receiving at least one-half support from the insured either—

(i) At the beginning of his or her period of disability;

(ii) At the time he or she became entitled to old-age or disability insurance benefits; or

(iii) If deceased, at the time of his or her death.

(2) If the insured did not have a period of disability at the time of his or her entitlement or death, you must have been receiving at least one-half support from the insured either—

(i) At the time he or she became entitled to old-age insurance benefits; or

(ii) If deceased, at the time of his or her death.

(d) *Amount and priority of reduction.* (1) If you became eligible for a Government pension after June 1983, we will reduce (to zero, if necessary) your monthly Social Security benefits as a spouse by two-thirds the amount of your monthly pension. If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(2) If you became eligible for a Government pension before July 1983 and do not meet one of the exceptions in paragraph (b) of this section, we will reduce (to zero, if necessary) your monthly Social Security benefits as a spouse by the full amount of your pension for months before December 1984 and by two-thirds the amount of your monthly pension for months after November 1984. If the reduction is not a multiple of 10 cents, we will round it to the next higher multiple of 10 cents.

(3) Your benefit as a spouse will be reduced, if necessary, for age and for simultaneous entitlement to other Social Security benefits before it is reduced because you are receiving a Government pension. In addition, this reduction follows the order of priority as stated in §404.402(b).

(4) If the monthly benefit payable to you after the required reduction(s) is

not a multiple of $1.00, we will reduce it to the next lower multiple of $1.00 as required by § 404.304(f).

(e) *When effective.* This reduction was put into the Social Security Act by the Social Security Amendments of 1977. It only applies to applications for benefits filed in or after December 1977 and only to benefits for December 1977 and later.

[49 FR 41245, Oct. 22, 1984; 50 FR 20902, May 21, 1985, as amended at 51 FR 23052, June 25, 1986; 60 FR 56513, Nov. 9, 1995]

§ 404.408b Reduction of retroactive monthly social security benefits where supplemental security income (SSI) payments were received for the same period.

(a) *When reduction is required.* We will reduce your retroactive social security benefits if—

(1) You are entitled to monthly social security benefits for a month or months before the first month in which those benefits are paid; and

(2) SSI payments (including federally administered State supplementary payments) which were made to you for the same month or months would have been reduced or not made if your social security benefits had been paid when regularly due instead of retroactively.

(b) *Amount of reduction.* Your retroactive monthly social security benefits will be reduced by the amount of the SSI payments (including federally administered State supplementary payments) that would not have been paid to you, if you had received your monthly social security benefits when they were regularly due instead of retroactively.

(c) *Benefits subject to reduction.* The reduction described in this section applies only to monthly social security benefits. Social security benefits which we pay to you for any month after you have begun receiving recurring monthly social security benefits, and for which you did not have to file a new application, are not subject to reduction. The lump-sum death payment, which is not a monthly benefit, is not subject to reduction.

(d) *Refiguring the amount of the reduction.* We will refigure the amount of the reduction if there are subsequent changes affecting your claim which relate to the reduction period described in paragraph (a) of this section. Refiguring is generally required where there is a change in your month of entitlement or the amount of your social security benefits or SSI payments (including federally administered State supplementary payments) for the reduction period.

(e) *Reimbursement of reduced retroactive monthly social security benefits.* The amount of the reduction will be—

(1) First used to reimburse the States for the amount of any federally administered State supplementary payments that would not have been made to you if the monthly social security benefits had been paid when regularly due instead of retroactively; and

(2) The remainder, if any, shall be covered into the general fund of the U.S. Treasury for the amount of SSI benefits that would not have been paid to you if the monthly social security benefits had been paid to you when regularly due instead of retroactively.

[47 FR 4988, Feb. 3, 1982]

§ 404.409 [Reserved]

§ 404.410 Reduction in benefits for age—general.

An individual's old-age insurance benefit, wife's or husband's benefit or widow's or widower's benefit is reduced if he or she is entitled to the benefit for a month before the month he or she reaches retirement age. For purposes of this section and §§404.411 through 404.413, retirement age is age 65; except that for months prior to January 1973, retirement age for widows and widowers is age 62. However, in the case of an individual entitled to wife's or husband's benefits, there is no reduction in benefits for any month he or she has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to child's insurance benefits. Similarly, in the case of an individual entitled to widow's or widower's benefits, such benefits will not be reduced below the amount an individual entitled to mother's or father's benefits would receive for any month he or she has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to

child's benefits. Reductions in benefits are, subject to §§404.411 through 404.413, made in the amounts described below:

(a) In the case of old-age insurance benefits, the individual's primary insurance amount is reduced by 5/9 of 1 percent multiplied by the number of months preceding the month in which he or she attains retirement age for which he or she is entitled to such benefits;

(b) In the case of wife's or husband's benefits, the individual's benefit amount before any reduction (see §§404.304 and 404.333) is reduced first (if necessary) for the family maximum under §404.403, and then further reduced by 25/36 of 1 percent multiplied by the number of months preceding the month in which he or she attains retirement age for which he or she is entitled to such benefits (but not including any month in which such wife or husband has in his or her care a child of the insured individual on whose earnings record he or she is entitled if the child is entitled to child's benefits);

(c)(1) In the case of widow's or widower's benefits, the individual's benefit amount (for months after December 1972, the amount equal to the insured person's primary insurance amount and for earlier months, the amounts described in §§404.304 and 404.338), after any reduction for the family maximum under §404.403, is reduced or further reduced by 19/40 of 1 percent multiplied by the number of months in the period beginning with the month of attainment of age 60 and ending with the month immediately before the month of attainment of age 65, for which he or she is entitled to such benefits (but not including any month in which such widow or widower has a child of the insured individual in his or her care if the child is entitled to child's benefits). For months prior to January 1973, the widow's or widower's benefit is reduced in the way described in the preceding sentence except that the percentage rate is 5/9 of 1 percent multiplied by the number of months from age 60 to 62 instead of 19/40 of 1 percent multiplied by the number of months from age 60 to 65.

(2) For those widows and widowers receiving benefits based on disability and whose entitlement begins prior to their attaining age 60, their benefits are—

(i) For months after December 1983, not subject to any reduction of their benefits in addition to that under paragraph (c)(1) of this section;

(ii) For the period January 1, 1973–December 31, 1983, subject to a reduction under paragraph (c)(1) of this section and an additional reduction formula of 43/240 of 1 percent multiplied by: (A) The benefit before any reduction for age and (B) the number of months of entitlement to such benefit in the period beginning with month of attainment of age 50 and ending with the month preceding month of attainment of age 60; and

(iii) For months prior to January 1973, subject to the reduction formula described in paragraph (c)(2)(ii) of this section with, however, the percentage rate set at 43/198 of 1 percent.

(d) Benefits reduced under this section may be later adjusted to eliminate reduction for certain months of entitlement prior to retirement age as provided in §404.412. For special provisions on reducing benefits for months prior to retirement age involving entitlement to two or more benefits and for reducing widow's and widower's benefits on the earnings record of a deceased individual previously entitled to old-age insurance benefits, see §§404.411 and 404.338, respectively.

[49 FR 24116, June 12, 1984]

§ 404.411 Special reduction in benefits for age involving entitlement to two or more benefits.

(a) *General.* (1) Except as specifically provided in this section, benefits of an individual entitled to more than one benefit will be reduced for months of entitlement before retirement age according to the provisions of §404.410. Such age reductions are made before any reduction under the provisions of §404.407.

(2) If an individual was born after January 1, 1928 and becomes disabled after December 31, 1989, his or her disability insurance benefits are reduced in accordance with paragraph (b)(1) of

this section. In other situations involving prior receipt of widow's or widower's insurance benefits, disability insurance benefits are reduced in accordance with paragraph (b)(2) of this section.

(3) If an individual was born after January 1, 1928, his or her old-age insurance benefits are reduced in accordance with § 404.410(a). In other situations involving prior receipt of widow's or widower's insurance benefits, old-age insurance benefits are reduced in accordance with paragraph (c) of this section.

(b) *Reduction in disability insurance benefits after entitlement to old-age insurance benefits, widow's or widower's benefits.* An individual's disability insurance benefits are reduced following entitlement to old-age insurance benefits, widow's or widower's insurance benefits (or following the month in which all conditions for entitlement to widow's or widower's insurance benefits are met except that the individual is entitled to an old-age insurance benefit which equals or exceeds the primary insurance amount on which the widow's or widower's insurance benefit is based) in accordance with the following provisions:

(1) In the case of an individual entitled to disability insurance benefits for a month after the month in which he becomes entitled to an old-age insurance benefit which is reduced for age under § 404.410, the disability insurance benefit is reduced by the amount by which the old-age insurance benefit would be reduced under § 404.410 if he attained age 65 in the first month of his most recent period of entitlement to disability insurance benefits.

(2) In the case of an individual who is first entitled to disability insurance benefits for a month in which or after which he or she attains age 62 and for which he or she is first entitled to a widow's or widower's insurance benefit (or would be so entitled except for entitlement to an equal or higher old-age insurance benefit as explained in the material preceding paragraph (b) of this section) before retirement age, the disability insurance benefits are reduced by the larger of:

(i) The amount the disability insurance benefit would have been reduced under paragraph (b)(1) of this section; or

(ii) The amount equal to the sum of the amount the widow's or widower's benefit would have been reduced under the provisions of § 404.410 if retirement age were 62 (instead of 65) plus the amount by which the disability insurance benefit would have been reduced under paragraph (b)(1) of this section if the benefit were equal to the excess of such benefit over the amount of the widow's or widower's benefit (without consideration of this paragraph (b)(2)) of this section.

(3) In the case of an individual who is first entitled to disability insurance benefits for a month before the month in which he or she attains age 62 and he or she is also entitled to a widow's or widower's insurance benefit (or would be so entitled except for entitlement to an equal or higher old-age insurance benefit as explained in the material preceding paragraph (b) of this section), the disability insurance benefit is reduced as if the widow or widower attained retirement age in the month immediately preceding the first month of his or her most recent period of entitlement to disability insurance benefits;

(c) *Reduction in old-age insurance benefits after entitlement to widow's or widower's insurance benefits.* An individual's old-age insurance benefit is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to a widow's or widower's insurance benefit to which he or she was first entitled for a month before attainment of retirement age or if, before attainment of retirement age, he or she met all conditions for entitlement to widow's or widower's benefits in or before the first month for which he or she was entitled to old-age insurance benefits except that the old-age insurance benefit equals or exceeds the primary insurance amount on which the widow's or widower's insurance benefit would be based. Under these circumstances, the old-age insurance benefit is reduced by the larger of the following:

(1) The amount by which the old-age insurance benefit would be reduced under the regular age reduction provisions of § 404.410; or

(2) An amount equal to the sum of:

(i) The amount by which the widow's or widower's insurance benefit would be reduced under § 404.410 for months prior to age 62; and

(ii) The amount by which the old-age insurance benefit would be reduced under § 404.410 if it were equal to the excess of the individual's primary insurance amount over the widow's or widower's insurance benefit before any reduction for age (but after any reduction for the family maximum under § 404.403).

(d) *Reduction in wife's or husband's insurance benefits when entitled to reduced old-age insurance benefits in the same month.* A wife's or husband's insurance benefit to which a person is first entitled in or after the month of attainment of age 62 is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to an old-age insurance benefit (but is not entitled to a disability insurance benefit) to which he or she was first entitled for a month before attainment of age 65. Under these circumstances, the wife's or husband's insurance benefit is reduced by the sum of:

(1) The amount by which the old-age insurance benefit would be reduced under the provisions of § 404.410; and

(2) The amount by which the wife's or husband's insurance benefit would be reduced under the provisions of § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the individual's own primary insurance amount.

(e) *Reduction in wife's, husband's, widow's or widower's insurance benefit because of entitlement to disability insurance benefits in the same month.* A wife's, husband's, widow's, or widower's insurance benefit to which a person is first entitled in or after the month of attainment of age 62 (or in the case of widow's or widower's insurance benefits, age 50) is reduced if, in his or her first month of entitlement to that benefit, he or she is also entitled to a disability insurance benefit. Under these circumstances, the wife's, husband's, widow's, or widower's insurance benefit is reduced by the sum of:

(1) The amount (if any) by which the disability insurance benefit is reduced under paragraph (b)(1) of this section, and

(2) The amount by which the wife's, husband's, widow's, or widower's insurance benefit would be reduced under § 404.410 if it were equal to the excess of such benefit (before any reduction for age but after reduction for the family maximum under § 404.403) over the disability insurance benefit (before any reduction under paragraph (b) of this section).

[40 FR 30816, July 23, 1975, as amended at 55 FR 50551, Dec. 7, 1990]

§ 404.412 Adjustments in benefit reductions for age.

(a) *General.* The following months are not counted for purposes of reducing benefits in accordance with § 404.410;

(1) Months subject to deduction under § 404.415, § 404.417, or § 404.422;

(2) In the case of wife's or husband's insurance benefits, any month in which she or he had a child of the insured individual in her or his care and for which the child was entitled to child's benefits;

(3) In the case of wife's or husband's insurance benefits, any month for which entitlement to such benefits is precluded because the insured person's disability ceased (and, as a result, the insured individual's entitlement to disability insurance benefits ended);

(4) In the case of widow's or widower's insurance benefits, any month in which she or he had in her or his care a child of the deceased insured individual and for which the child was entitled to child's benefits;

(5) In the case of widow's or widower's insurance benefits, any month before attainment of age 62 and any month between age 62 and attainment of age 65 for which he or she was not entitled to such benefits;

(6) In the case of old-age insurance benefits, any month for which the individual was entitled to disability insurance benefits.

(b) *Adjustment by Social Security Administration.* Adjustments in benefits to exclude those months of entitlement which are described in paragraphs (a)(1) through (6) of this section from consideration in determining the amount by which such benefits are reduced are

made automatically. Each year the Social Security Administration examines beneficiary records to identify those instances in which an individual has attained age 65 (or age 62 in the case of widow's or widower's insurance benefits) and one or more months described in paragraphs (a) (1) through (6) of this section occurred prior to such age during the period of entitlement to benefits reduced for age. Increases in benefit amounts based upon this adjustment are effective with the month of attainment of age 65, or in the case of widow's and widower's insurance benefits, the month of attainment of age 65 or age 62 (whichever applies).

[40 FR 30817, July 23, 1975, as amended at 49 FR 24117, June 12, 1984]

§ 404.413 Reduction in benefits for age following an increase in primary insurance amounts.

(a) *General.* When an individual's benefits have been reduced for age under the provisions of §§ 404.410 through 404.411, the primary insurance amount on which such benefits are based may be subsequently increased because of recomputation, a general benefit increase pursuant to an amendment of the Act, or increases based upon rises in the cost-of-living under section 215(i) of the Social Security Act. Where the individual's benefits are increased because of an increase in the primary insurance amount, such benefits are reduced separately under §§ 404.410 and 404.411. The benefit amount for months before the effective date of the increase in the primary insurance amount is reduced under § 404.410 (and § 404.411, if applicable) and added to the amount of increase in benefit amount which has been reduced for months of entitlement to the increase prior to the individual's retirement age; the resulting sum will be the total benefit amount to which the individual is entitled for the month of such increase and months thereafter.

(b) *Subsequent reduction of increases in reduced benefit after 1977 applies as or original entitlement.* When an individual's benefits have been reduced for age and the benefit is increased after 1977 due to a rise in the primary insurance amount, the amount of the increase to which the individual is entitled is proportionately reduced as provided in paragraph (c) of this section. When an individual is entitled to more than one benefit which is reduced for age, the rules for reducing the benefit increases apply to each reduced benefit.

(c) *How reduction is computed*—(1) *Entitlement to reduced benefits after 1977.* If an individual becomes entitled after 1977 to a benefit reduced for age, and the primary insurance amount on which the reduced benefit is based is increased, the amount of the increase payable to the individual is reduced by the same percentage as used to reduce the benefit in the month of initial entitlement. Where the reduced benefit of an individual has been adjusted at age 65 (age 62 and 65 for widows) any increase to which the individual becomes entitled thereafter is reduced by the adjusted percentage.

(2) *Entitlement to reduced benefits before 1978.* An individual who became entitled to a benefit reduced for age before 1978, and whose benefit may be increased as a result of an increase in the primary insurance amount after 1977, shall have the amount of the benefit to which he or she is entitled increased by the same percentage as the increase in the primary insurance amount.

[40 FR 30817, July 23, 1975, as amended at 43 FR 33706, Aug. 1, 1978]

§ 404.415 Deductions because of excess earnings; annual earnings test.

(a) *Deductions because of beneficiary's earnings.* Under the annual earnings test, deductions are made from monthly benefits (except disability insurance benefits, child's insurance benefits based on the child's disability, or widow's or widower's insurance benefits based on the widow's or widower's disability) payable to a beneficiary for each month in a taxable year (whether a calendar year or a fiscal year) beginning after December 1954 in which the beneficiary is under age 72 (age 70 after December 1982) and to which excess earnings are charged under the provisions described in § 404.434.

(b) *Deductions from husband's, wife's, or child's benefits because of excess earnings of the insured individual.* Deductions are made from the wife's, husband's, or child's insurance benefits payable (or deemed payable—see § 404.420) on the insured individual's

earnings record because of the excess earnings of the insured individual under the provisions described in § 404.416. However, beginning with January 1985, deductions will not be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

[32 FR 19159, Dec. 20, 1967, as amended at 48 FR 4281, Jan. 31, 1983; 51 FR 11912, Apr. 8, 1986]

§ 404.416 Amount of deduction because of excess earnings.

(a) *Deductions because of excess earnings of insured individual.* For taxable years beginning after 1960, or ending after June 1961, if excess earnings (as described in § 404.430) of an insured individual are chargeable under the annual earnings test to a month, a deduction is made from the total of the benefits payable to him and to all other persons entitled (or deemed entitled—see § 404.420) on his earnings record for that month. This deduction is an amount equal to that amount of the excess earnings so charged. (See § 404.434 concerning the manner of charging such excess earnings.) However, beginning with January 1985, deductions will not be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years, and the divorced spouse will be considered as not entitled for purposes of computing the amount of deductions from other beneficiaries.

(b) *Deductions because of excess earnings of other beneficiary.* For taxable years beginning after 1960, or ending after June 1961, if benefits are payable to a person entitled (or deemed entitled—see § 404.420) on the earnings record of the insured individual, and such person has excess earnings (as described in § 404.430) charged to a month, a deduction is made from his benefits only for that month. This deduction is an amount equal to the amount of the excess earnings so charged. (See § 404.434 for charging of excess earnings where both the insured individual and such person have excess earnings.)

[43 FR 8132, Feb. 28, 1978, as amended at 51 FR 11912, Apr. 8, 1986]

§ 404.417 Deductions because of noncovered remunerative activity outside the United States; 45 hour and 7-day work test.

(a) *Deductions because of individual's activity*—(1) *Prior to May 1983.* For months prior to May 1983, a 7-day work test applies in a month before benefit deductions are made for noncovered remunerative activity outside the United States. A deduction is made from any monthly benefit (except disability insurance benefits, child's insurance benefits based on the child's disability, or widow's or widower's insurance benefits based on the widow's or widower's disability) payable to an individual for each month in a taxable year beginning after December 1954 in which the beneficiary, while under age 72 (age 70 after December 1982), engages in noncovered remunerative activity (see § 404.418) outside the United States on 7 or more different calendar days. The deduction is for an amount equal to the benefit payable to the individual for that month.

(2) *From May 1983 on.* Effective May 1983, a 45-hour work test applies before a benefit deduction is made for the non-covered remunerative activity performed outside the United States in a month by the type of beneficiary described in paragraph (a)(1) of this section.

(b) *Deductions from benefits because of the earnings or work of an insured individual*—(1) *Prior to September 1984.* Where the insured individual entitled to old-age benefits works on 7 or more days in a month prior to September 1984 while under age 72 (age 70 after December 1982), a deduction is made for that month from any:

(i) Wife's, husband's, or child's insurance benefit payable on the insured individual's earnings record; and

(ii) Mother's, father's, or child's insurance benefit based on child's disability, which under § 404.420 is deemed payable on the insured individual's earnings record because of the beneficiary's marriage to the insured individual.

(2) *From September 1984 on.* Effective September 1984, a benefit deduction is made for a month from the benefits described in paragraph (b)(1) of this section only if the insured individual,

while under age 70, has worked in excess of 45 hours in that month.

(3) *Amount of deduction.* The amount of the deduction required by this paragraph (b) is equal to the wife's, husband's or child's benefit.

(4) *From January 1985 on.* Effective January 1985, no deduction will be made from the benefits payable to a divorced wife or a divorced husband who has been divorced from the insured individual for at least 2 years.

[49 FR 24117, June 12, 1984, as amended at 51 FR 11912, Apr. 21, 1986; 52 FR 26145, July 13, 1987]

§ 404.418 "Noncovered remunerative activity outside the United States," defined.

An individual is engaged in noncovered remunerative activity outside the United States for purposes of deductions described in § 404.417 if:

(a) He performs services outside the United States as an employee and the services do not constitute employment as defined in subpart K of this part and, for taxable years ending after 1955, the services are not performed in the active military or naval service of the United States; or

(b) He carries on a trade or business outside the United States (other than the performance of services as an employee) the net income or loss of which is not includable in computing his net earnings from self-employment (as defined in § 404.1050) for a taxable year and would not be excluded from net earnings from self-employment (see § 404.1052) if the trade or business were carried on in the United States. When used in the preceding sentence with respect to a trade or business, the term *United States* does not include the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam or American Samoa, in the case of an alien who is not a resident of the United States (including the Commonwealth of Puerto Rico, the Virgin Islands and, with respect to taxable years beginning after 1960, Guam and American Samoa), and the term *trade or business* shall have the same meaning as when used in section 162 of the Internal Revenue Code of 1954.

§ 404.420 Persons deemed entitled to benefits based on an individual's earnings record.

For purposes of imposing deductions under the annual earnings test (see § 404.415) and the foreign work test (see § 404.417), a person who is married to an old-age insurance beneficiary and who is entitled to a mother's or father's insurance benefit or a child's insurance benefit based on the child's disability (and all these benefits are based on the earnings record of some third person) is deemed entitled to such benefit based on the earnings record of the old-age insurance beneficiary to whom he or she is married. This section is effective for months in any taxable year of the old-age insurance beneficiary that begins after August 1958.

[49 FR 24117, June 12, 1984]

§ 404.421 Deductions because beneficiary failed to have a child in his or her care.

Deductions for failure to have a child in care (as defined in subpart D of this part) are made as follows:

(a) *Wife's or husband's insurance benefits.* A deduction is made from the wife's or husband's insurance benefit to which he or she is entitled for any month if he or she is under age 65 and does not have in his or her care a child of the insured entitled to a child's insurance benefit. However, a deduction is not made for any month in which he or she is age 62 or over, but under age 65, and there is in effect a certificate of election for him or her to receive an actuarially reduced wife's or husband's insurance benefit for such month (see subpart D of this part).

(b) *Mother's or father's insurance benefits*—(1) *Widow or Widower.* A deduction is made from the mother's or father's insurance benefit to which he or she is entitled as the widow or widower (see subpart D of this part) of the deceased individual upon whose earnings such benefit is based, for any month in which he or she does not have in his or her care a child who is entitled to a child's insurance benefit based on the earnings of the deceased insured individual.

(2) *Surviving divorced mother or father.* A deduction is made from the mother's or father's insurance benefit to which

he or she is entitled as the surviving divorced mother or father (see subpart D of this part) of the deceased individual upon whose earnings record such benefit is based, for any month in which she or he does not have in care a child of the deceased individual who is her or his son, daughter, or legally adopted child and who is entitled to a child's insurance benefit based on the earnings of the deceased insured individual.

(c) *Amount to be deducted.* The amount deducted from the benefit, as described in paragraphs (a) and (b) of this section, is equal to the amount of the benefit which is otherwise payable for the month in which she or he does not have a child in his or her care.

(d) *When child is considered not entitled to benefits.* For purposes of paragraphs (a) and (b) of this section a person is considered not entitled to a child's insurance benefit for any month in which he is age 18 or over, and:

(1) Is entitled to a child's insurance benefit based on his own disability and a deduction is made from the child's insurance benefit because of his refusal of rehabilitation services as described in § 404.422(b); or

(2) Is entitled to a child's insurance benefit because he is a full-time student at an educational institution. This paragraph applies to benefits for months after December 1964.

[32 FR 19159, Dec. 20, 1967, as amended at 49 FR 24117, June 12, 1984]

§ 404.422 Deductions because of refusal to accept rehabilitation services.

(a) *Deductions because individual entitled to disability insurance benefits refuses rehabilitation services*—(1) *Disability insurance beneficiary.* A deduction is made from any benefit payable to a disability insurance beneficiary for each month in which he refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act.

(2) *Other beneficiaries.* For each month in which a deduction is made from an individual's disability insurance benefit because of his refusal to accept rehabilitation services (as described in paragraph (a)(1) of this section), a deduction is also made from:

(i) Any wife's, husband's, or child's insurance benefit payable for that month on the earnings record of the individual entitled to disability insurance benefits;

(ii) Benefits payable for that month to the disability insurance beneficiary's spouse who is entitled (on the earnings record of a third person) to a mother's insurance benefit or to a child's insurance benefit based on disability.

(b) *Deductions because individual entitled to a child's insurance benefit based on disability refuses rehabilitation services.* A deduction is made from any benefit payable to an individual who has attained age 18 and is entitled to a child's insurance benefit based on disability, for each month in which he refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act unless, in that month, he is a full-time student at an educational institution.

(c) *Deductions because individual entitled to widow's or widower's insurance benefit based on disability refuses rehabilitation services*—(1) *Widow's insurance beneficiary.* A deduction is made from any benefits payable to an individual entitled to a widow's insurance benefit based on disability for each month in which she is under age 60 and refuses without good cause to accept rehabilitation services available to her under a State plan approved under the Vocational Rehabilitation Act.

(2) *Widower's insurance beneficiary.* A deduction is made from any benefits payable to an individual entitled to a widower's insurance benefit based on disability for each month in which he is under age 60 (age 62 for months prior to January 1973) and refuses without good cause to accept rehabilitation services available to him under a State plan approved under the Vocational Rehabilitation Act.

(d) *Amount of deduction.* The amount deducted from an individual's benefit for a month under the provisions of paragraph (a), (b), or (c) of this section is an amount equal to the benefit otherwise payable for that month.

(e) *Good cause for refusal of rehabilitation services.* An individual may refuse to accept rehabilitation services (for the purposes of paragraph (a), (b), or (c) of this section) if his refusal is based on good cause. In determining whether an individual has good cause for refusing rehabilitation services, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual to refuse such services. We also consider other factors that may have caused an individual to refuse such services. For example, an individual has good cause for refusing rehabilitation services where:

(1) The individual is a member or adherent of any recognized church or religious sect which teaches its members or adherents to rely solely, in the treatment and care of any physical or mental impairment, on prayer or spiritual means through the application and use of the tenets or teachings of such church or sect; and

(2) His refusal to accept rehabilitation services was due solely to his adherence to the teachings or tenets of his church or sect.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9429, Apr. 16, 1973; 59 FR 1633, Jan. 12, 1994]

§ 404.423 Manner of making deductions.

Deductions provided for in §§ 404.415, 404.417, 404.421, and 404.422 (as modified in § 404.458) are made by withholding benefits (in whole or in part, depending upon the amount to be withheld) for each month in which an event causing a deduction occurred. If the amount to be deducted is not withheld from the benefits payable in the month in which the event causing the deduction occurred, such amount constitutes a *deduction overpayment* and is subject to adjustment or recovery in accordance with the provisions of subpart F of this part.

§ 404.424 Total amount of deductions where more than one deduction event occurs in a month.

If more than one of the deduction events specified in §§ 404.415, 404.417, and 404.421 occurred in any 1 month, each of which would occasion a deduction equal to the benefit for such month, only an amount equal to such benefit is deducted.

§ 404.425 Total amount of deductions where deduction events occur in more than 1 month.

If a deduction event described in §§ 404.415, 404.417, 404.421, and 404.422 occurs in more than 1 month, the total amount deducted from an individual's benefits is equal to the sum of the deductions for all months in which any such event occurred.

§ 404.428 Earnings in a taxable year.

(a) *General.* (1) In applying the annual earnings test (see § 404.415(a)) under this subpart, all of a beneficiary's earnings (as defined in § 404.429) for all months of the beneficiary's taxable year are used even though the individual may not be entitled to benefits during all months of the taxable year. (See, however, § 404.430 for the rule which applies to earnings of a beneficiary who attains age 72 during the taxable year (age 70 for months after December 1982)).

(2) The taxable year of an employee is presumed to be a calendar year until it is shown to the satisfaction of the Social Security Administration that the individual has a different taxable year. A self-employed individual's taxable year is a calendar year unless the individual has a different taxable year for the purposes of subtitle A of the Internal Revenue Code of 1954. In either case, the number of months in a taxable year is not affected by—(i) The time a claim for social security benefits is filed, (ii) attainment of any particular age, (iii) marriage or the termination of marriage, or (iv) adoption. For beneficiaries who die on or before November 10, 1988, a taxable year ends with the month of the death of the beneficiary. The month of death is counted as a month of the deceased beneficiary's taxable year in determining whether the beneficiary had excess earnings for the year under § 404.430. For beneficiaries who die after November 10, 1988, the number of months used in determining whether the beneficiary

had excess earnings for the year under § 404.430 is 12.

(b) *When derived.* Wages as defined in § 404.429(c) are derived and includable as earnings for the months and year in which the beneficiary rendered the services. Net earnings from self-employment, or net losses therefrom, are derived, or incurred, and are includable as earnings or losses, in the year for which such earnings or losses are reportable for Federal income tax purposes.

[32 FR 19159, Dec. 20, 1967, as amended at 45 FR 48116, July 18, 1980; 48 FR 4282, Jan. 31, 1983; 55 FR 37461, Sept. 12, 1990]

§ 404.429 Earnings; defined.

(a) *General.* When the term *earnings* is used in this subpart other than as a part of the phrase *net earnings from self-employment,* it means an individual's earnings for a taxable year after 1954. It includes the sum of his wages for services rendered in such year, and his net earnings from self-employment for the taxable year, minus any net loss from self-employment for the same taxable year.

(b) *Net earnings from self-employment; net loss from self-employment.* An individual's net earnings from self-employment and his net loss from self-employment are determined under the provisions in subpart K of this part except that:

1) For the purposes of this section, the provisions in subpart K of this part shall not apply that exclude from the definition of *trade or business* the following occupations:

(i) The performance of the functions of a public office;

(ii) The performance of a service of a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by the order;

(iii) The performance of service by an individual in the exercise of his profession as a Christian Science practitioner;

(iv) For taxable years ending before 1965, the performance by an individual in the exercise of his profession as a doctor of medicine;

(v) For taxable years ending before 1956, the performance of service by an individual in the exercise of his profession as a lawyer, dentist, osteopath, veterinarian, chiropractor, naturopath, or optometrist.

(2) For the sole purpose of the earnings test under this subpart—

(i) An individual who has attained age 65 on or before the last day of his or her taxable year shall have excluded from his or her gross earnings from self-employment, royalties attributable to a copyright or patent obtained before the taxable year in which he or she attained age 65 if the copyright or patent is on property created by his or her own personal efforts; and

(ii) An individual entitled to insurance benefits, under title II of the Act, other than disability insurance benefits or child's insurance benefits payable by reason of being under a disability, shall have excluded from gross earnings for any year after 1977 any self-employment income received in a year after his or her initial year of entitlement that is not attributable to services performed after the first month he or she became entitled to benefits. As used in this paragraph (b)(2)(ii) of this section, *services* means any significant work activity performed by the individual in the operation or management of a trade, profession, or business which can be related to the income received. Such services will be termed *significant services.* Where a portion of the income received in a year is not related to any significant services performed after the month of initial entitlement, only that portion may be excluded from gross earnings for deduction purposes. The balance of the income counts for deduction purposes. Not counted as *significant services* are—

(A) Actions taken after the initial month of entitlement to sell a crop or product if the crop or product was completely produced or created in or before the month of entitlement. This rule does not apply to income received by an individual from a trade or business of buying and selling products produced or made by others; for example, a grain broker.

(B) Those activities that are related solely to protecting an investment in a currently operating business or that are too irregular, occasional, or minor

to be considered as having a bearing on the income received, such as—

(*1*) Hiring an agent, manager, or other employee to operate the business;

(*2*) Signing contracts where the owner's signature is required so long as the major contract negotiations were handled by the owner's agent, manager, or other employees in running the business for the owner;

(*3*) Looking over the company's financial records to assess the effectiveness of those agents, managers, or employees in running the business for the owner;

(*4*) Personally contacting an old and valued customer solely for the purpose of maintaining good will when such contact has a minimal effect on the ongoing operation of the trade or business; or

(*5*) Occasionally filling in for an agent, manager, or other employee or partner in an emergency.

(iii) An individual is presumed to have royalties or other self-employment income countable for purposes of the earnings test until it is shown to the satisfaction of the Social Security Administration that such income may be excluded under § 404.429(b)(2) (i) or (ii).

(3) In figuring an individual's net earnings or net loss from self-employment, all net income or net loss is includable even though (i) the individual did not perform personal services in carrying on the trade or business, (ii) the net profit was less than $400, (iii) the net profit was in excess of the maximum amount creditable to his earnings record, or (iv) the net profit was not reportable for social security tax purposes.

(4) An individual's net earnings from self-employment is the excess of gross income over the allowable business deductions (allowed under the Internal Revenue Code). An individual's net loss from self-employment is the excess of business deductions (that are allowed under the Internal Revenue Code) over gross income. Expenses arising in connection with the production of income excluded from gross income under § 404.429(b)(2)(ii) cannot be deducted from wages or net earnings from self-employment that are not excluded under that section.

(c) *Wages defined.* Wages include the gross amount of an individual's wages rather than the net amount paid after deductions by the employer for items such as taxes and insurance. For purposes of this section, an individual's wages are determined under the provisions of subpart K of this part, except that, notwithstanding the provisions of subpart K, wages also includes:

(1) Remuneration in excess of the amounts in the annual wage limitation table in § 404.1047;

(2) Cash remuneration of less than $50 paid in a calendar quarter to an employee for (i) domestic service in the private home of the employer, or (ii) service not in the course of the employer's trade or business; and

(3) Payments for agricultural labor excluded under § 404.1055.

(4) Remuneration, cash and noncash, for service as a homeworker even though the cash remuneration paid the employee is less than $50 in a calendar quarter; and

(5) For taxable years ending after 1955, services performed outside the United States in the military or naval service of the United States; and

(6) Remuneration for services excepted from employment performed within the United States by an individual as an employee that are for that reason not considered wages under subpart K of this part, if the remuneration for such services is not includable in computing his net earnings from self-employment or net loss from self-employment, as defined in paragraph (b) of this section.

(d) *Presumptions concerning wages.* For purposes of this section, where reports received by the Administration show wages (as defined in paragraph (c) of this section) were paid to an individual during a taxable year, it is presumed that they were paid to him for services rendered in that year until such time as it is shown to the satisfaction of the Administration that the wages were paid for services rendered in another taxable year. If the reports of wages paid to an individual show his wages for a calendar year, the individual's taxable year is presumed to be a calendar year for purposes of this section

until it is shown to the satisfaction of the Administration that his taxable year is not a calendar year.

[32 FR 19159, Dec. 20, 1967, as amended at 41 FR 13912, Apr. 1, 1976; 47 FR 46690, Oct. 20, 1982; 52 FR 8249, Mar. 17, 1987; 57 FR 59913, Dec. 17, 1992]

§ 404.430 Excess earnings defined for taxable years ending after December 1972; monthly exempt amount defined.

(a) *Method of determining excess earnings for years ending after December 1972.* For taxable years ending after 1972, an individual's excess earnings for a taxable year are 50 percent of his or her earnings (as described in § 404.429) for the year which are above the exempt amount. For an individual who has attained retirement age, as defined in section 216(l) of the Act, excess earnings for a taxable year beginning after December 31, 1989, are 33⅓ percent of his or her earnings (as described in § 404.429) for the year which are above the exempt amount. For deaths after November 10, 1988, an individual who dies in the taxable year in which he or she would have attained retirement age shall have his or her excess earnings computed as if he or she had attained retirement age. The exempt amount is obtained by multiplying the number of months in the taxable year (except that the number of months in the taxable year in which the individual dies shall be 12, if death occurs after November 10, 1988) by the following applicable monthly exempt amount.

(1) $175 for taxable years ending after December 1972 and before January 1974;

(2) $200 for taxable years beginning after December 1973 and before January 1975; and

(3) The exempt amount for taxable years ending after December 1974, as determined under paragraphs (c) and (d) of this section. However, earnings in and after the month an individual attains age 72 will not be used to figure excess earnings for retirement test purposes. For the employed individual, wages for months prior to the month of attainment of age 72 are used to figure the excess earnings for retirement test purposes. For the self-employed individual, the pro rata share of the net earnings or net loss for the taxable year for the period prior to the month of attainment of age 72 is used to figure the excess earnings. If the beneficiary was not engaged in self-employment prior to the month of attainment of age 72, any subsequent earnings or losses from self-employment in the taxable year will not be used to figure the excess earnings. Where the excess amount figured under the provisions of this section is not a multiple of $1, it is reduced to the next lower dollar. (All references to age 72 will be age 70 for months after December 1982.)

Example 1. The self-employed beneficiary attained age 72 in July 1979. His net earnings for 1979, his taxable year, were $12,000. The pro rata share of the net earnings for the period prior to July is $6,000. His excess earnings for 1979 for retirement test purposes are $750. This is computed by subtracting $4,500 ($375×12), the exempt amount for 1979, from $6,000 and dividing the result by 2.

Example 2. The beneficiary attained age 72 in July 1979. His taxable year was calendar year 1979. His wages for the period prior to July were $6,000. From August through December 1979, he worked in self-employment and had net earnings in the amount of $2,000. His net earnings from self-employment are not used to figure his excess earnings. Only his wages for the period prior to July 1979 ($6,000) are used to figure his excess earnings. As in example 1, his excess earnings are $750.

Example 3. The facts are the same as in example 2, except that the beneficiary worked in self-employment throughout all of 1979 and had a net loss of $500 from the self-employment activity. The pro rata share of the net loss for the period prior to July is $250. His earnings for the taxable year to be used in figuring excess earnings are $5,750.

This is computed by subtracting the $250 net loss from self-employment from the $6,000 in wages. The excess earnings are $625 (($5,750 − $4,500) ÷ 2).

(b) *Monthly exempt amount defined.* The retirement test monthly exempt amount is the amount of wages which a social security beneficiary may earn in any month without part of his or her monthly benefit being deducted because of excess earnings. For benefits payable for months after 1977, the monthly exempt amount applies only in a beneficiary's grace year or years. (See § 404.435 (a) and (c)).

(c) *Method of determining monthly exempt amount for taxable years ending after December 1974.* (1) Except as provided under paragraph (d) of this section, for purposes of paragraph (a)(3) of

this section, the applicable monthly exempt amount effective for an individual's taxable year that ends in the calendar year after the calendar year in which an automatic cost-of-living increase in old-age, survivors, and disability insurance benefits is effective is the larger of—

(i) The exempt amount in effect for months in the taxable year in which the exempt amount determination is being made; or

(ii) The amount determined by:

(A) Multiplying the monthly exempt amount effective during the taxable year in which the exempt amount determination is being made by the ratio of:

(*1*) The average amount, per employee, of the taxable wages of all employees as reported to the Commissioner for the first calendar quarter of the calendar year in which the exempt amount determination is made, to

(*2*) The average amount, per employee, of the taxable wages of all employees as reported to the Commissioner for the first calendar quarter of the most recent calendar year in which an increase in the exempt amount was enacted or a determination resulting in such an increase was made, and

(B) Rounding the result of such multiplication:

(*1*) To the next higher multiple of $10 where such result is a multiple of $5 but not of $10, or

(*2*) to the nearest multiple of $10 in any other case.

(2) For purposes of paragraph (c)(1) of this section, *reported for the first calendar quarter* means reported for such first calendar quarter and posted to the earnings records by the Commissioner on or before the last day of the Social Security Administration's quarterly updating operations in September of the same year. Earnings items received or posted thereafter are not counted even though they pertain to the first quarter.

(d) *Method of determining monthly exempt amount for taxable years ending after December 1977 for beneficiaries, age 65 or over.* (1) For purposes of paragraph (a)(3) of this section, for all months of taxable years ending after 1977, the applicable monthly exempt amount for an individual who has attained (or, but for the individual's death occurring after November 10, 1988, would have attained) retirement age as defined in section 216(l) of the Act before the close of the taxable year involved is—

(i) $333.33⅓ for each month of any taxable year ending in 1978;

(ii) $375 for each month of any taxable year ending in 1979;

(iii) $416.66⅔ for each month of any taxable year ending in 1980; and

(iv) $458.33⅓ for each month of any taxable year ending in 1981;

(v) $500 for each month of any taxable year ending in 1982;

(vi) $550 for each month of any taxable year ending in 1983;

(vii) $580 for each month of any taxable year ending in 1984;

(viii) $610 for each month of any taxable year ending in 1985;

(ix) $650 for each month of any taxable year ending in 1986;

(x) $680 for each month of any taxable year ending in 1987;

(xi) $700 for each month of any taxable year ending in 1988;

(xii) $740 for each month of any taxable year ending in 1989; and

(xiii) $780 for each month of any taxable year ending in 1990.

(2) Fractional amounts listed in paragraph (d)(1) of this section shall be rounded to the next higher whole dollar amount, unless the individual shows that doing so results in a different grace year (see § 404.435 (a) and (c)).

[40 FR 42865, Sept. 17, 1975; 40 FR 45805, Oct. 3, 1975, as amended at 45 FR 48117, July 18, 1980; 45 FR 58107, Sept. 2, 1980; 48 FR 4282, Jan. 31, 1983; 55 FR 37461, Sept. 12, 1990; 62 FR 38450, July 18, 1997]

§ 404.434 Excess earnings; method of charging.

(a) *Months charged.* For purposes of imposing deductions for taxable years after 1960, the excess earnings (as described in § 404.430) of an individual are charged to each month beginning with the first month the individual is entitled in the taxable year in question and continuing, if necessary, to each succeeding month in such taxable year until all of the individual's excess earnings have been charged. Excess earnings, however, are not charged to

any month described in §§ 404.435 and 404.436.

(b) *Amount of excess earnings charged*—(1) *Insured individual's excess earnings.* The insured individual's excess earnings are charged on the basis of $1 of excess earnings for each $1 of monthly benefits to which he and all other persons are entitled (or deemed entitled—see § 404.420) for such month on the insured individual's earnings record. (See § 404.439 where the excess earnings for a month are less than the total benefits payable for that month.)

(2) *Excess earnings of beneficiary other than insured individual.* The excess earnings of a person other than the insured individual are charged on the basis of $1 of excess earnings for each $1 of monthly benefits to which he is entitled (see § 404.437) for such month. The excess earnings of such person, however, are charged only against his own benefits.

(3) *Insured individual and person entitled (or deemed entitled) on his earnings record both have excess earnings.* If both the insured individual and a person entitled (or deemed entitled) on his earnings record have excess earnings (as described in § 404.430), the insured individual's excess earnings are charged first against the total family benefits payable (or deemed payable) on his earnings record, as described in paragraph (b)(1) of this section. Next, the excess earnings of a person entitled on the insured individual's earnings record are charged (as described in paragraph (c)(2) of this section) against his own benefits, but only to the extent that his benefits have not already been charged with the excess earnings of the insured individual. See § 404.441 for an example of this process and the manner in which partial monthly benefits are apportioned.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.435 Excess earnings; months to which excess earnings cannot be charged.

(a) *Monthly benefits payable for months after 1977.* Beginning with monthly benefits payable for months after 1977, no matter how much a beneficiary earns in a given taxable year, no deduction on account of excess earnings will be made in the benefits payable for any month—

(1) In which he or she was not entitled to a monthly benefit;

(2) In which he or she was considered not entitled to benefits (due to noncovered work outside the United States, no child in care, or refusal of rehabilitation, as described in § 404.436);

(3) In which he or she was age 72 or over (age 70 for months after December 1982);

(4) In which he or she was entitled to payment of disability insurance benefit;

(5) In which he or she was age 18 or over and entitled to a child's insurance benefit based on disability;

(6) In which he or she was entitled to a widow's or widower's insurance benefit based on disability; or

(7) Which was a *nonservice* month (see paragraph (b) of this section) in the beneficiary's *grace year* (see paragraph (c) of this section).

(b) *Nonservice month defined.* A nonservice month is any month in which an individual, while entitled to retirement or survivors benefits—(1) does not work in self-employment (see paragraphs (d) and (e) of this section); (2) does not perform services for wages greater than the monthly exempt amount set for that month (see paragraph (f) of this section and § 404.430 (b), (c), and (d)); and (3) does not work in noncovered remunerative activity on 7 or more days in a month while outside the United States. A nonservice month occurs even if there are no excess earnings in the year.

(c) *Grace year defined.* (1) A beneficiary's initial grace year is the first taxable year after 1977 in which the beneficiary has a nonservice month (see paragraph (b) of this section) in or after the month in which he or she is entitled to a retirement, auxiliary, or survivor's benefit.

(2) A beneficiary may have another grace year each time his or her entitlement to one type of benefit ends and, after a break in entitlement of at least one month, he or she becomes entitled to a different type of retirement or survivors benefit. The new grace year would then be the taxable year in

which occurs the first nonservice month after the break in entitlement.

(3) A month will not be counted as a nonservice month for purposes of determining whether a given year is a beneficiary's grace year if the nonservice month occurred while the beneficiary was entitled to disability benefits under section 223 of the Social Security Act or as a disabled widow, widower, or child under section 202.

(4) A beneficiary entitled to child's benefits, to young wife's or young husband's benefits (entitled only by reason of having a child in his or her care), or to mother's or father's benefits, is entitled to a termination grace year in any year(s) the beneficiary's entitlement to these types of benefits terminates. This provision does not apply if the termination is because of death or if the beneficiary is entitled to a Social Security benefit for the month following the month in which the entitlement ended. The beneficiary is entitled to a termination grace year in addition to any other grace year(s) available to him or her.

Example 1: Don, age 65, will retire from his regular job in April of next year. Although he will have earned $11,000 for January–April of that year and plans to work part time, he will not earn over the monthly exempt amount after April. Don's taxable year is the calendar year. Since next year will be the first year in which he has a nonservice month while entitled to benefits, it will be his grace year and he will be entitled to the monthly earnings test for that year only. He will receive benefits for all months in which he does not earn over the monthly exempt amount (May–December) even though his earnings have substantially exceeded the annual exempt amount. However, in the years that follow, only the annual earnings test will be applied if he has earnings that exceed the annual exempt amount, regardless of his monthly earnings.

Example 2: Marion was entitled to mother's insurance benefits from 1978 because she had a child in her care under age 18. Because she had a nonservice month in 1978, 1978 was her initial grace year. Marion's child married in May 1980 and entitlement to mother's benefits terminated in April 1980. Since Marion's entitlement did not terminate by reason of her death and she was not entitled to another type of Social Security benefit in the month after her entitlement to mother's benefit ended, she is entitled to a termination grace year for 1980, the year in which her entitlement to mother's insurance benefits terminated.

She applied for and became entitled to widow's insurance benefits effective February 1981. Because there was a break in entitlement to benefits of at least one month before entitlement to another type of benefit, 1981 will be a subsequent grace year if Marion has a nonservice month in 1981.

(d) *When an individual works in self-employment.* An individual works in self-employment in any month in which he or she performs substantial services (see § 404.446) in the operation of a trade or business (or in a combination of trades and businesses if there are more than one) as an owner or partner even though there may be no earnings or net earnings caused by the individual's services during the month.

(e) *Presumption regarding work in self-employment.* An individual is presumed to have worked in self-employment in each month of the individual's taxable year until it is shown to the satisfaction of the Social Security Administration that in a particular month the individual did not perform substantial services (see § 404.446(c)) in any trade or business (or in a combination of trades and businesses if there are more than one) from which the net income or loss is included in computing the individual's annual earnings (see § 404.429).

(f) *Presumption regarding services for wages.* An individual is presumed to have performed services in any month for wages (as defined in § 404.429) of more than the applicable monthly exempt amount set for that month until it is shown to the satisfaction of the Social Security Administration that the individual did not perform services in that month for wages of more than the monthly exempt amount.

[45 FR 48117, July 18, 1980, as amended at 47 FR 46691, Oct. 20, 1982; 48 FR 4282, Jan. 31, 1983]

§ 404.436 Excess earnings; months to which excess earnings cannot be charged because individual is deemed not entitled to benefits.

Under the annual earnings test, excess earnings (as described in § 404.430) are not charged to any month in which an individual is deemed not entitled to a benefit. A beneficiary (i.e., the insured individual or any person entitled or deemed entitled on the individual's earnings record) is deemed not entitled to a benefit for a month if he is subject

to a deduction for that month because of:

(a) Engaging in noncovered remunerative activity outside the United States (as described in §§ 404.417 and 404.418); or

(b) Failure to have a child in her care (in the case of a wife under age 65 or a widow or surviving divorced mother under age 62, as described in § 404.421); or

(c) Refusal by a person entitled to a child's insurance benefit based on disability to accept rehabilitation services (as described in § 404.422). (An insured individual's excess earnings are not charged against the benefit of a child entitled (or deemed entitled) on the insured individual's earnings record for any month in which the child is subject to a deduction for refusing rehabilitation services); or

(d) Refusal by an individual entitled to a disability insurance benefit to accept rehabilitation services as described in § 404.422 (e.g., a wife's excess earnings may not be charged against her benefits for months in which the disability insurance beneficiary on whose account she is entitled to wife's benefits incurs a deduction because he refuses rehabilitation services; also, a woman's earnings may not be charged against the mother's insurance benefit or child's insurance benefit she is receiving (on the earnings record of another individual) for months in which her husband refuses rehabilitation services while he is entitled to a disability insurance benefit).

(e) Refusal by a person entitled before age 60 to a widow's/or to a widower's insurance benefit based on disability (before age 62 in the case of a widower's insurance benefit for months before 1973) to accept rehabilitation services (as described in § 404.422).

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9429, Apr. 16, 1973; 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.437 Excess earnings; benefit rate subject to deductions because of excess earnings.

For purposes of deductions because of excess earnings (as described in § 404.430), the benefit rate against which excess earnings are charged is the amount of the benefit (other than a disability insurance benefit) to which the person is entitled for the month:

(a) After reduction for the *maximum* (see §§ 404.403 and 404.404). The rate as reduced for the maximum as referred to in this paragraph is the one applicable to remaining entitled beneficiaries after exclusion of beneficiaries deemed not entitled under § 404.436 (due to a deduction for engaging in noncovered remunerative activity outside the United States, failure to have a child in her care, or refusal to accept rehabilitation services);

(b) After any reduction under section 202(q) of the Act because of entitlement to benefits for months before age 65 (this applies only to old-age, wife's, widow's, or husband's benefits);

(c) After any reduction in benefits payable to a person entitled (or deemed entitled; see § 404.420) on the earnings record of the insured individual because of entitlement on his own earnings record to other benefits (see § 404.407); and

(d) After any reduction of benefits payable to a person entitled or deemed entitled on the earnings record of an individual entitled to a disability insurance benefit because of such individual's entitlement to workmen's compensation for months after 1965 (see § 404.408).

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 17716, July 3, 1973; 43 FR 8133, Feb. 28, 1978]

§ 404.439 Partial monthly benefits; excess earnings of the individual charged against his benefits and the benefits of persons entitled (or deemed entitled) to benefits on his earnings record.

Deductions are made against the total family benefits where the excess earnings (as described in § 404.430) of an individual entitled to old-age insurance benefits are charged to a month and require deductions in an amount less than the total family benefits payable on his earnings record for that month (including the amount of a mother's or child's insurance benefit payable to a spouse who is deemed entitled on the individual's earnings record—see § 404.420). The difference between the total benefits payable and the deductions made under the annual earnings

test for such month is paid (if otherwise payable under title II of the Act) to each person in the proportion that the benefit to which each is entitled (before the application of the reductions described in § 404.403 for the family maximum, § 404.407 for entitlement to more than one type of benefit, and section 202(q) of the Act for entitlement to benefits before retirement age) and before the application of § 404.304(f) to round to the next lower dollar bears to the total of the benefits to which all of them are entitled, except that the total amount payable to any such person may not exceed the benefits which would have been payable to that person if none of the insured individual's excess earnings had been charged to that month.

Example: A is entitled to an old-age insurance benefit of $165 and his wife is entitled to $82.50 before rounding, making a total of $247.50. After A's excess earnings have been charged to the appropriate months, there remains a partial benefit of $200 payable for October, which is apportioned as follows:

	Original benefit	Fraction of original	Benefit[1]
A	$165	2/3	$133
Wife	82.50	1/3	66
Total	247.50		199

[1] After deductions for excess earnings and after rounding per § 404.304(f).

[38 FR 9429, Apr. 16, 1973, as amended at 38 FR 17717, July 3, 1973; 43 FR 8133, Feb. 28, 1978; 48 FR 46149, Oct. 11, 1983]

§ 404.440 Partial monthly benefits; prorated share of partial payment exceeds the benefit before deduction for excess earnings.

Where, under the apportionment described in § 404.439, a person's prorated share of the partial benefit exceeds the benefit rate to which he was entitled before excess earnings of the insured individual were charged, such person's share of the partial benefit is reduced to the amount he would have been paid had there been no deduction for excess earnings (see example). The remainder of the partial benefit is then paid to other persons eligible to receive benefits in the proportion that the benefit of each such other person bears to the total of the benefits to which all such other persons are entitled (before reduction for the family maximum). Thus, if only two beneficiaries are involved, payment is made to one as if no deduction had been imposed; and the balance of the partial benefit is paid to the other. If three or more beneficiaries are involved, however, reapportionment of the excess of the beneficiary's share of the partial benefit over the amount he would have been paid without the deduction is made in proportion to his original entitlement rate (before reduction for the family maximum). If the excess amount involved at any point totals less than $1, it is not reapportioned; instead, each beneficiary is paid on the basis of the last calculation.

Example: Family maximum is $150. Insured individual's excess earnings charged to the month are $25. The remaining $125 is prorated as partial payment.

	Original benefit	Fraction of original total benefit	Benefit after deductions for excess earnings but before reduction for family maximum	Benefit reduced for maximum but without deductions for excess earnings	Benefit payable after both deductions and reductions (and rounded)
Insured Individual	$100	2/5	50	100.00	75
Wife	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16
Child	50	1/5	25	16.60	16

[32 FR 19159, Dec. 20, 1967, as amended at 48 FR 46149, Oct. 11, 1983]

§ 404.441 Partial monthly benefits; insured individual and another person entitled (or deemed entitled) on the same earnings record both have excess earnings.

Where both the insured individual and another person entitled (or deemed entitled) on the same earnings record have excess earnings (as described in § 404.430), their excess earnings are charged, and their partial monthly benefit is apportioned, as follows:

Example: M and his wife are initially entitled to combined total benefits of $264 per month based on M's old-age insurance benefit of $176. For the taxable year in question, M's excess earnings were $1,599 and his wife's excess earnings were $265. Both were under age 65. M had wages of more than $340 in all months of the year except February, while his wife had wages of more than $340 in all months of the year. After M's excess earnings have been charged to the appropriate months (all months through July except February), there remains a partial benefit payment for August of $249, which is allocated to M and his wife in the ratio that the original benefit of each bears to the sum of their original benefits: $166 and $83. His wife's excess earnings are charged against her full benefit for February ($88), her partial benefit for August ($83), her full benefit for September, and from $6 of her October benefit, leaving an $82 benefit payable to her for that month.

[48 FR 46149, Oct. 11, 1983]

§ 404.446 Definition of "substantial services" and "services."

(a) *General.* In general, the substantial services test will be applicable only in a grace year (including a termination grace year) as defined in § 404.435(c)(1). It is a test of whether, in view of all the services rendered by the individual and the surrounding circumstances, the individual reasonably can be considered retired in the month in question. In determining whether an individual has or has not performed substantial services in any month, the following factors are considered:

(1) The amount of time the individual devoted to all trades and businesses;

(2) The nature of the services rendered by the individual;

(3) The extent and nature of the activity performed by the individual before he allegedly retired as compared with that performed thereafter;

(4) The presence or absence of an adequately qualified paid manager, partner, or family member who manages the business;

(5) The type of business establishment involved;

(6) The amount of capital invested in the trade or business; and

(7) The seasonal nature of the trade or business.

(b) *Individual engaged in more than one trade or business.* When an individual, in any month, performs services in more than one trade or business, his services in all trades or businesses are considered together in determining whether he performed substantial services in self-employment in such month.

(c) *Evidentiary requirements.* An individual who alleges that he did not render substantial services in any month, or months, shall submit detailed information about the operation of the trades or businesses, including the individual's activities in connection therewith. When requested to do so by the Administration, the individual shall also submit such additional statements, information, and other evidence as the Administration may consider necessary for a proper determination of whether the individual rendered substantial services in self-employment. Failure of the individual to submit the requested statements, information, and other evidence is a sufficient basis for a determination that the individual rendered substantial services in self-employment during the period in question.

[32 FR 19159, Dec. 20, 1967, as amended at 47 FR 46691, Oct. 20, 1982]

§ 404.447 Evaluation of factors involved in substantial services test.

In determining whether an individual's services are substantial, consideration is given to the following factors:

(a) *Amount of time devoted to trades or businesses.* Consideration is first given to the amount of time the self-employed individual devotes to all trades or businesses, the net income or loss of which is includable in computing his earnings as defined in § 404.429. For the purposes of this paragraph, the time devoted to a trade or business includes all the time spent by the individual in

any activity, whether physical or mental, at the place of business or elsewhere in furtherance of such trade or business. This includes the time spent in advising and planning the operation of the business, making business contacts, attending meetings, and preparing and maintaining the facilities and records of the business. All time spent at the place of business which cannot reasonably be considered unrelated to business activities is considered time devoted to the trade or business. In considering the weight to be given to the time devoted to trades or businesses the following rules are applied:

(1) *Forty-five hours or less in a month devoted to trade or business.* Where the individual establishes that the time devoted to his trades and businesses during a calendar month was not more than 45 hours, the individual's services in that month are not considered substantial unless other factors (see paragraphs (b), (c), and (d) of this section) make such a finding unreasonable. For example, an individual who worked only 15 hours in a month might nevertheless be found to have rendered substantial services if he was managing a sizable business or engaging in a highly skilled occupation. However, the services of less than 15 hours rendered in all trades and businesses during a calendar month are not substantial.

(2) *More than 45 hours in a month devoted to trades and businesses.* Where an individual devotes more than 45 hours to all trades and businesses during a calendar month, it will be found that the individual's services are substantial unless it is established that the individual could reasonably be considered retired in the month and, therefore, that such services were not, in fact, substantial.

(b) *Nature of services rendered.* Consideration is also given to the nature of the services rendered by the individual in any case where a finding that the individual was retired would be unreasonable if based on time alone (see paragraph (a) of this section). The more highly skilled and valuable his services in self-employment are, the more likely the individual rendering such services could not reasonably be considered retired. The performance of services regularly also tends to show that the individual has not retired. Services are considered in relation to the technical and management needs of the business in which they are rendered. Thus, skilled services of a managerial or technical nature may be so important to the conduct of a sizable business that such services would be substantial even though the time required to render the services is considerably less than 45 hours.

(c) *Comparison of services rendered before and after retirement.* Where consideration of the amount of time devoted to a trade or business (see paragraph (a) of this section) and the nature of services rendered (see paragraph (b) of this section) is not sufficient to establish whether an individual's services were substantial, consideration is given to the extent and nature of the services rendered by the individual before his *retirement,* as compared with the services performed during the period in question. A significant reduction in the amount or importance of services rendered in the business tends to show that the individual is retired; absence of such reduction tends to show that the individual is not retired.

(d) *Setting in which services performed.* Where consideration of the factors described in paragraphs (a), (b), and (c) of this section is not sufficient to establish that an individual's services in self-employment were or were not substantial, all other factors are considered. The presence or absence of a capable manager, the kind and size of the business, the amount of capital invested and whether the business is seasonal, as well as any other pertinent factors, are considered in determining whether the individual's services are such that he can reasonably be considered retired.

§ 404.450 Required reports of work outside the United States or failure to have care of a child.

(a) *Beneficiary engaged in noncovered remunerative activity; report by beneficiary.* Any individual entitled to a benefit which is subject to a deduction in that month because of noncovered remunerative activity outside the United States (see § 404.417) shall report the occurrence of such an event to the

Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which such event occurred.

(b) *Beneficiary receiving wife's, husband's, mother's or father's insurance benefits does not have care of a child; report by beneficiary.* Any person receiving wife's, husband's, mother's, or father's insurance benefits which are subject to a deduction (as described in § 404.421) because he or she did not have a child in his or her care shall report the occurrence of such an event to the Social Security Administration before the receipt and acceptance of a benefit for the second month following the month in which the deduction event occurred.

(c) *Report required by person receiving benefits on behalf of another.* Where a person is receiving benefits on behalf of a beneficiary (see subpart U of this part) it is his duty to make the report to the Administration required by paragraph (a) or (b) of this section, on behalf of the beneficiary.

(d) *Report; content and form.* A report required under the provisions of this section shall be filed with the Social Security Administration. (See § 404.614 of this part for procedures concerning place of filing and date of receipt of such a report.) The report should be made on a form prescribed by the Administration and in accordance with instructions, printed thereon or attached thereto, as prescribed by the Administration. Prescribed forms may be obtained at any office of the Administration. If the prescribed form is not used, the report should be properly identified (e.g., show the name and social security claim number of the beneficiary about whom the report is made), describe the events being reported, tell when the events occurred, furnish any other pertinent data (e.g., who has care of the children), and be properly authenticated (e.g., bear the signature and address of the beneficiary making the report or the person reporting on his behalf). The report should contain all the information needed for a proper determination of whether a deduction applies and, if it does, the period for which such deductions should be made.

[32 FR 19159, Dec. 20, 1967, as amended at 49 FR 24117, June 12, 1984; 51 FR 10616, Mar. 28, 1986; 65 FR 16813, Mar. 30, 2000]

§ 404.451 Penalty deductions for failure to report within prescribed time limit noncovered remunerative activity outside the United States or not having care of a child.

(a) *Penalty for failure to report.* If an individual (or the person receiving benefits on his behalf) fails to comply with the reporting obligations of § 404.450 within the time specified in § 404.450 and it is found that good cause for such failure does not exist (see § 404.454), a penalty deduction is made from the individual's benefits in addition to the deduction described in § 404.417 (relating to noncovered remunerative activity outside the United States) or § 404.421 (relating to failure to have care of a child).

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report noncovered remunerative activity outside the United States or not having care of a child within the prescribed time is determined as follows:

(1) *First failure to make timely report.* The penalty deduction for the first failure to make a timely report is an amount equal to the individual's benefit or benefits for the first month for which the deduction event was not reported timely.

(2) *Second failure to make timely report.* The penalty deduction for the second failure to make a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the first month for which the deduction event in the second failure period was not reported timely.

(3) *Subsequent failures to make timely reports.* The penalty deduction for the third or subsequent failure to file a timely report is an amount equal to three times the amount of the individual's benefit or benefits for the first month for which the deduction event in the third failure period was not reported timely.

(c) *Determining whether a failure to file a timely report is first, second, third, or subsequent failure*—(1) *Failure period.* A

failure period runs from the date of one delinquent report (but initially starting with the date of entitlement to monthly benefits) to the date of the next succeeding delinquent report, excluding the date of the earlier report and including the date of the later report. The failure period includes each month for which succeeding delinquent report, excluding a report becomes overdue during a failure period, but it does not include any month for which a report is not yet overdue on the ending date of such period. If *good cause* (see § 404.454) is found for the entire period, the period is not regarded as a failure period.

(2) *First failure.* When no penalty deduction under paragraph (b) of this section has previously been imposed against the beneficiary for failure to report noncovered remunerative activity outside the United States or for failure to report not having care of a child, the earliest month in the first failure period for which a report is delinquent and for which *good cause* (see § 404.454) for failure to make the required report is not found is considered to be the first failure.

(3) *Second failure.* After one penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the second failure period is considered to be the second failure.

(4) *Third and subsequent failures.* After a second penalty deduction under paragraph (b) of this section has been imposed against the beneficiary, the first month for which a report is delinquent in the third failure period is considered to be the third failure. Subsequent failures will be determined in the same manner.

Example: M became entitled in January 1966 to mother's benefits; these benefits are not payable for any month in which the mother does not have a child in her care. M accepted benefits for each month from January 1966 through June 1967. In July 1967 she reported that she had not had a child in her care in January 1967. As she was not eligible for a benefit for any month in which she did not have a child in her care, M's July 1967 benefit was withheld to recover the overpayment she had received for January 1967, and the next payment she received was for August 1967. No penalty was imposed for her failure to make a timely report of the deduction event that occurred in January 1967 because it was determined that *good cause* existed.

In March 1968 M reported that she had not had a child in her care in September or October 1967; however, she had accepted benefit payments for each month from August 1967 through February 1968. Her benefits for March and April 1968 were withheld to recover the overpayment for September and October 1967. Also, it was determined that *good cause* was not present for M's failure to make a timely report of the deduction event that had occurred in September 1967. A penalty equal to her benefit for September 1967 was deducted from M's May 1968 payment since this was her *first failure* to report not having a child in her care. Payments to her then were continued.

On November 4, 1968, it was learned that M had not had a child in her care in November 1967 or in June, July, or August 1968 although she had accepted benefits for June through October 1968. Consequently, M's benefits for November 1968 through February 1969 were withheld to recover the 4 months' overpayment she received for months in which she did not have a child in her care. In addition, it was determined that *good cause* was not present for M's failure to report the deduction events, and a penalty was imposed equal to twice the amount of M's benefit for the month of June 1968. This was M's *second failure* to report not having a child in her care. No further penalty applied for November 1967 because that month was included in M's *first-failure* period.

(5) *Penalty deductions imposed under § 404.453 not considered.* A failure to make a timely report of earnings as required by § 404.452 for which a penalty deduction is imposed under § 404.453 is not counted as a failure to report in determining the first or subsequent failure to report noncovered remunerative activity outside the United States or not having care of a child.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to make a timely report of noncovered remunerative activity outside the United States or for failure to report not having care of a child may not exceed the number of months in that failure period for which the individual received and accepted a benefit and for which a deduction is imposed by reason of his noncovered remunerative activity outside the United States or failure to have

care of a child. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[38 FR 3596, Feb. 8, 1973, as amended at 38 FR 9430, Apr. 16, 1973]

§ 404.452 Reports to Social Security Administration of earnings; wages; net earnings from self-employment.

(a) *Conditions under which a report of earnings, wages, and net earnings from self-employment is required.* An individual who, during a taxable year, is entitled to a monthly benefit (except if in each month of his taxable year he was entitled only to a disability insurance benefit) is required to report to the Social Security Administration the total amount of his earnings (as defined in § 404.429) for each such taxable year. A report is required when the individual's total earnings or wages (as defined in § 404.429) for any taxable year ending after 1972 exceed the product of $175 multiplied by the number of months in his taxable year, except that the report is not required for a taxable year if:

(1) The individual attained the age of 70 in or before the first month of entitlement to benefits in the taxable year, or

(2) The individual's benefit payments were suspended under the provisions described in § 404.456 for all months in a taxable year in which the individual was entitled to benefits and was under age 70.

(b) *Time within which report must be filed.* The report for any taxable year beginning after 1954 shall be filed with the Social Security Administration on or before the 15th day of the fourth month following the close of the taxable year; for example, April 15 when the beneficiary's taxable year is a calendar year. (See § 404.3(c) where the last day for filing the report falls on a Saturday, Sunday, or legal holiday, or any other day all or part of which is declared to be a nonwork day for Federal employees by statute or Executive order.) The filing of an income tax return or a form W–2 with the Internal Revenue Service may serve as the report required to be filed under the provisions of this section where the income tax return or form W–2 shows the same wages and net earnings from self-employment that must be reported to the Administration under this section.

(c) *Report required by person receiving benefits on behalf of another.* Where a person is receiving benefits on behalf of a beneficiary (see subpart U of this part), it is his duty to make the report to the Administration required by this section.

(d) *Information to be provided to us.* The report should show the name and social security claim number of the beneficiary about whom the report is made; identify the taxable year for which the report is made; show the total amount of wages for which the beneficiary rendered services during the taxable year (if applicable), the amount of net earnings from self-employment for such year (if applicable); and show the name and address of the individual making the report. To overcome the presumption that the beneficiary rendered services for wages exceeding the allowable amount and rendered substantial services in self-employment in each month (see § 404.435), we must also be told the specific months in which the beneficiary did not render services in employment for wages of more than the allowable amount (as described in § 404.435) and did not render substantial services in self-employment (as described in §§ 404.446 and 404.447).

(e) *Requirement to furnish requested information.* A beneficiary, or the person reporting on his behalf, is required to furnish any other information about the beneficiary's earnings and services that the Administration requests for the purpose of determining the correct amount of benefits payable for a taxable year (see § 404.455).

(f) *Extension of time for filing report*—(1) *General.* Notwithstanding the provision described in paragraph (b) of this section, the Administration may grant a reasonable extension of time for making the report of earnings required under this section if it finds that there is valid reason for a delay, but in no case may the period be extended more than 4 months for any taxable year.

(2) *Requirements applicable to requests for extensions.* Before his annual report of earnings is due, a beneficiary may request an extension of time for filing

his report. The request must meet all of these requirements:

(i) Be in writing, and

(ii) Be made by the beneficiary, his representative payee, or his authorized agent,

(iii) Be made before the required report is overdue (If an extension of time already has been granted, a request for further extension must be made before the due date as extended previously),

(iv) Be made to an office of the Administration,

(v) Name the beneficiary for whom the annual report must be made and furnish his claim number,

(vi) Identify the year for which an annual report is due and for which an extension of time is requested,

(vii) Explain in the requester's own words the reasons why an extension of time is needed, and how much extended time is needed,

(viii) Show the date the request is made, and

(ix) Be signed by the requester.

(3) *Valid reason defined.* A valid reason is a bona fide need, problem, or situation which makes it impossible or difficult for a beneficiary (or his representative payee) to meet the annual report due date prescribed by law. This may be illness or disability of the one required to make the report, absence or travel so far from home that he does not have and cannot readily obtain the records needed for making his report, inability to obtain evidence required from another source when such evidence is necessary in making the report, inability of his accountant to compile the data needed for the annual report, or any similar situation which has a direct bearing on the individual's ability to comply with his reporting obligation within the specified time limit.

(4) *Evidence that extension of time has been granted.* In the absence of written evidence of a properly approved extension of time for making an annual report of earnings, it will be presumed that no extension of filing time was granted. In such case it will be necessary for the beneficiary to establish whether he otherwise had good cause (§ 404.454) for filing his annual report after the normal due date.

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 9430, Apr. 16, 1973; 43 FR 8133, Feb. 28, 1978; 51 FR 10616, Mar. 28, 1986; 60 FR 56513, Nov. 9, 1995; 62 FR 15610, Apr. 2, 1997]

§ 404.453 Penalty deductions for failure to report earnings timely.

(a) *Penalty for failure to report earnings; general.* Penalty deductions are imposed against an individual's benefits, in addition to the deductions required because of his excess earnings (see § 404.415), if:

(1) He fails to make a timely report of his earnings as specified in § 404.452 for a taxable year beginning after 1954;

(2) It is found that good cause for failure to report earnings timely (see § 404.454) does not exist;

(3) A deduction is imposed because of his earnings (see § 404.415) for that year; and

(4) He received and accepted any payment of benefits for that year.

(b) *Determining amount of penalty deduction.* The amount of the penalty deduction for failure to report earnings for a taxable year within the prescribed time is determined as follows:

(1) *First failure to file timely report.* The penalty deduction for the first failure to file a timely report is an amount equal to the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during the taxable year, except that with respect to any deductions imposed on or after January 2, 1968, if the amount of the deduction imposed for the taxable year is less than the benefit or benefits for the last month of the taxable year for which he was entitled to a benefit under section 202 of the Act, the penalty deduction is an amount equal to the amount of the deduction imposed but not less than $10.

(2) *Second failure to file timely report.* The penalty deduction for the second failure to file a timely report is an amount equal to twice the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(3) *Subsequent failures to file timely reports.* The penalty deduction for the third or subsequent failure to file a

timely report is an amount equal to three times the amount of the individual's benefit or benefits for the last month for which he was entitled to such benefit or benefits during such taxable year.

(c) *Determining whether a failure to file a timely report is first, second, or subsequent failure*—(1) *No prior failure.* Where no penalty deduction under this section has previously been imposed against the beneficiary for failure to make a timely report of his earnings, all taxable years (and this may include 2 or more years) for which a report of earnings is overdue as of the date the first delinquent report is made are included in the first failure. The latest of such years for which *good cause* for failure to make the required report (see § 404.454) is not found is considered the first failure to file a timely report.

Example: X became entitled to benefits in 1964 and had reportable earnings for 1964, 1965, and 1966. He did not make his annual reports for those years until July 1967. At that time it was found that 1966 was the only year for which he has good cause for not making a timely report of his earnings. Since all taxable years for which a report is overdue as of the date of the first delinquent report are included in the first failure period, it was found that his first failure to make a timely report was for 1965. The penalty is equal to his December 1965 benefit rate. If good cause had also been found for both 1965 and 1964, then X would have *no prior failure* within the meaning of this subsection.

(2) *Second and subsequent failures.* After one penalty deduction under paragraph (b) of this section has been imposed against an individual, each taxable year for which a timely report of earnings is not made (and the count commences with reports of earnings which become delinquent after the date the first delinquent report described in paragraph (c)(1) of this section was made), and for which *good cause* for failure to make the required report is not found, is considered separately in determining whether the failure is the second or subsequent failure to report timely.

Example: Y incurred a penalty deduction for not making his 1963 annual report until July 1964. In August 1966 it was found that he had not made a timely report of either his 1964 or 1965 earnings, and good cause was not present with respect to either year. The penalty for 1964 is equal to twice his benefit rate for December 1964. The penalty for 1965 is equal to three times his benefit rate for December 1965.

(3) *Penalty deduction imposed under § 404.451 not considered.* A failure to make a report as required by § 404.450, for which a penalty deduction is imposed under § 404.451, is not counted as a failure to report in determining, under this section, whether a failure to report earnings or wages is the first or subsequent failure to report.

(d) *Limitation on amount of penalty deduction.* Notwithstanding the provisions described in paragraph (b) of this section, the amount of the penalty deduction imposed for failure to file a timely report of earnings for a taxable year may not exceed the number of months in that year for which the individual received and accepted a benefit and for which deductions are imposed by reason of his earnings for such year. (See § 404.458 for other limitations on the amount of the penalty deduction.)

[32 FR 19159, Dec. 20, 1967, as amended at 38 FR 3597, Feb. 8, 1973; 38 FR 9431, Apr. 16, 1973]

§ 404.454 Good cause for failure to make required reports.

(a) *General.* The failure of an individual to make a timely report under the provisions described in §§ 404.450 and 404.452 will not result in a penalty deduction if the individual establishes to the satisfaction of the Administration that his failure to file a timely report was due to good cause. Before making any penalty determination as described in §§ 404.451 and 404.453, the individual shall be advised of the penalty and good cause provisions and afforded an opportunity to establish good cause for failure to report timely. The failure of the individual to submit evidence to establish good cause within a specified time may be considered a sufficient basis for a finding that good cause does not exist (see § 404.705). In determining whether good cause for failure to report timely has been established by the individual, consideration is given to whether the failure to report within the proper time limit was the result of untoward circumstances, misleading action of the Social Security Administration, confusion as to the requirements of the Act resulting

from amendments to the Act or other legislation, or any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have. For example, *good cause* may be found where failure to file a timely report was caused by:

(1) Serious illness of the individual, or death or serious illness in his immediate family;

(2) Inability of the individual to obtain, within the time required to file the report, earnings information from his employer because of death or serious illness of the employer or one in the employer's immediate family; or unavoidable absence of his employer; or destruction by fire or other damage of the employer's business records;

(3) Destruction by fire, or other damage, of the individual's business records;

(4) Transmittal of the required report within the time required to file the report, in good faith to another Government agency even though the report does not reach the Administration until after the period for reporting has expired;

(5) Unawareness of the statutory provision that an annual report of earnings is required for the taxable year in which the individual attained age 72 provided his earnings for such year exceeded the applicable amount, e.g., $1,680 for a 12-month taxable year ending after December 1967;

(6) Failure on the part of the Administration to furnish forms in sufficient time for an individual to complete and file the report on or before the date it was due, provided the individual made a timely request to the Administration for the forms;

(7) Belief that an extension of time for filing income tax returns granted by the Internal Revenue Service was also applicable to the annual report to be made to the Social Security Administration;

(8) Reliance upon a written report to the Social Security Administration made by, or on behalf of, the beneficiary before the close of the taxable year, if such report contained sufficient information about the beneficiary's earnings or work, to require suspension of his benefits (see § 404.456) and the report was not subsequently refuted or rescinded; or

(9) Failure of the individual to understand reporting responsibilities due to his or her physical, mental, educational, or linguistic limitation(s).

(b) *Notice of determination.* In every case in which it is determined that a penalty deduction should be imposed, the individual shall be advised of the penalty determination and of his reconsideration rights. If it is found that good cause for failure to file a timely report does not exist, the notice will include an explanation of the basis for this finding; the notice will also explain the right to partial adjustment of the overpayment, in accordance with the provisions of § 404.502(c).

(c) *Good cause for subsequent failure.* Where circumstances are similar and an individual fails on more than one occasion to make a timely report, good cause normally will not be found for the second or subsequent violation.

[38 FR 3597, Feb. 8, 1973, as amended at 43 FR 8133, Feb. 28, 1978; 59 FR 1634, Jan. 12, 1994]

§ 404.455 Request by Social Security Administration for reports of earnings and estimated earnings; effect of failure to comply with request.

(a) *Request by Social Security Administration for report during taxable year; effect of failure to comply.* The Social Security Administration may, during the course of a taxable year, request a beneficiary to estimate his or her earnings (as defined in § 404.429) for the current taxable year and for the next taxable year, and to furnish any other information about his or her earnings that the Social Security Administration may specify. If a beneficiary fails to comply with a request for an estimate of earnings for a taxable year, the beneficiary's failure, in itself, constitutes justification under section 203(h) of the Act for a determination that it may reasonably be expected that the beneficiary will have deductions imposed under the provisions described in § 404.415, due to his or her earnings for that taxable year. Furthermore, the failure of the beneficiary to comply with a request for an estimate of earnings for a taxable year will, in itself, constitute justification for the Social Security Administration to use the

preceding taxable year's estimate of earnings (or, if available, reported earnings) to suspend payment of benefits for the current or next taxable year.

(b) *Request by Social Security Administration for report after close of taxable year; failure to comply.* After the close of his or her taxable year, the Social Security Administration may request a beneficiary to furnish a report of his or her earnings for the closed taxable year and to furnish any other information about his or her earnings for that year that the Social Security Administration may specify. If he or she fails to comply with this request, this failure shall, in itself, constitute justification under section 203(h) of the Act for a determination that the beneficiary's benefits are subject to deductions as described in § 404.415 for each month in the taxable year (or only for the months thereof specified by the Social Security Administration).

[56 FR 11373, Mar. 18, 1991]

§ 404.456 Current suspension of benefits because an individual works or engages in self-employment.

(a) *Circumstances under which benefit payments may be suspended.* If, on the basis of information obtained by or submitted to the Administration, it is determined that an individual entitled to monthly benefits for any taxable year may reasonably be expected to have deductions imposed against his benefits (as described in § 404.415) by reason of his earnings for such year, the Administration may, before the close of the taxable year, suspend all or part, as the Administration may specify, of the benefits payable to the individual and to all other persons entitled (or deemed entitled—see § 404.420) to benefits on the basis of the individual's earnings record.

(b) *Duration of suspension.* The suspension described in paragraph (a) of this section shall remain in effect with respect to the benefits for each month until the Administration has determined whether or not any deduction under § 404.415 applies for such month.

(c) *When suspension of benefits becomes final.* For taxable years beginning after August 1958, if benefit payments were suspended (as described in paragraph (a) of this section) for all months of entitlement in an individual's taxable year, no benefit payment for any month in that year may be made after the expiration of the period of 3 years, 3 months, and 15 days following the close of the individual's taxable year unless, within that period, the individual, or any person entitled to benefits based on his earnings record, files with the Administration information showing that a benefit for a month is payable to the individual. Subject to the limitations of this paragraph, a determination about deductions may be reopened under the circumstances described in § 404.907.

[32 FR 19159, Dec. 20, 1967, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.457 Deductions where taxes neither deducted from wages of certain maritime employees nor paid.

(a) *When deduction is required.* A deduction is required where:

(1) An individual performed services after September 1941 and before the termination of Title I of the First War Powers Act, 1941, on or in connection with any vessel as an officer or crew member; and

(2) The services were performed in the employ of the United States and employment was through the War Shipping Administration or, for services performed before February 11, 1942, through the United States Maritime Commission; and

(3) The services, under the provisions of § 404.1041 of this part, constituted employment for the purposes of title II of the Social Security Act; and

(4) The taxes imposed (by section 1400 of the Internal Revenue Code of 1939, as amended) with respect to such services were neither deducted from the individual's wages nor paid by the employer.

(b) *Amount of deduction.* The deduction required by paragraph (a) of this section is an amount equal to 1 percent of the wages with respect to which the taxes described in paragraph (a)(4) of this section were neither deducted nor paid by the employer.

(c) *How deduction is made.* The deduction required by paragraph (a) of this section is made by withholding an amount as determined under paragraph

(b) of this section from any monthly benefit or lump-sum death payment based on the earnings record of the individual who performed the services described in paragraph (a) of this section.

[32 FR 19159, Dec. 20, 1967, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.458 Limiting deductions where total family benefits payable would not be affected or would be only partly affected.

Notwithstanding the provisions described in §§ 404.415, 404.417, 404.421, 404.422, 404.451, and 404.453 about the amount of the deduction to be imposed for a month, no such deduction is imposed for a month when the benefits payable for that month to all persons entitled to benefits on the same earnings record and living in the same household remain equal to the maximum benefits payable to them on that earnings record. Where making such deductions and increasing the benefits to others in the household (for the month in which the deduction event occurred) would give members of the household less than the *maximum* (as determined under § 404.404) payable to them, the amount of deduction imposed is reduced to the difference between the maximum amount of benefits payable to them and the total amount which would have been paid if the benefits of members of the household not subject to deductions were increased for that month. The individual subject to the deduction for such month may be paid the difference between the deduction so reduced and his benefit as adjusted under § 404.403 (without application of § 404.402(a)). All other persons in the household are paid, for such month, their benefits as adjusted under § 404.403 without application of § 404.402(a).

[47 FR 43673, Oct. 4, 1982]

§ 404.460 Nonpayment of monthly benefits of aliens outside the United States.

(a) *Nonpayment of monthly benefits to aliens outside the United States more than 6 months.* Except as described in paragraph (b) and subject to the limitations in paragraph (c) of this section after December 1956 no monthly benefit may be paid to any individual who is not a citizen or national of the United States, for any month after the sixth consecutive calendar month during all of which he is outside the United States, and before the first calendar month for all of which he is in the United States after such absence. (See § 404.380 regarding special payments at age 72.)

(1) For nonpayment of benefits under this section, it is necessary that the beneficiary be an alien and while an alien be outside the United States for more than six full consecutive calendar months. In determining whether at the time of a beneficiary's initial entitlement to benefits he has been outside the United States for a period exceeding six full consecutive calendar months, not more than the six calendar months immediately preceding the month of initial entitlement may be considered. For the purposes of this section, *outside the United States* means outside the territorial boundaries of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands of the United States, Guam, and American Samoa.

(2) Effective with 6-month periods beginning after January 2, 1968, after an alien has been outside the United States for any period of 30 consecutive days, he is deemed to be outside the United States continuously until he has returned to the United States and remained in the United States for a period of 30 consecutive days.

(3) Payments which have been discontinued pursuant to the provisions of this section will not be resumed until the alien beneficiary has been in the United States for a full calendar month. A full calendar month includes 24 hours of each day of the calendar month.

(4) Nonpayment of benefits to an individual under this section does not cause nonpayment of benefits to other persons receiving benefits based on the individual's earnings record.

Example: R, an alien, leaves the United States on August 15, 1967, and returns on February 1, 1968. He leaves again on February 15, 1968, and does not return until May 15, 1968, when he spends 1 day in the United States. He has been receiving monthly benefits since July 1967.

R's first 6-month period of absence begins September 1, 1967. Since this period begins

before January 2, 1968, his visit (Feb. 1, 1968, to Feb. 15, 1968) to the United States for less than 30 consecutive days is sufficient to break this 6-month period.

R's second 6-month period of absence begins March 1, 1968. Since this period begins after January 2, 1968, and he was outside the United States for 30 consecutive days, he must return and spend 30 consecutive days in the United States prior to September 1, 1968, to prevent nonpayment of benefits beginning September 1968. If R fails to return to the United States for 30 consecutive days prior to September 1, 1968, payments will be discontinued and will not be resumed until R spends at least 1 full calendar month in the United States.

(b) *When nonpayment provisions do not apply*. The provisions described in paragraph (a) of this section do not apply, subject to the limitations in paragraph (c) of this section, to a benefit for any month if:

(1) The individual was, or upon application would have been, entitled to a monthly benefit for December 1956, based upon the same earnings record; or

(2)(i) The individual upon whose earnings the benefit is based, before that month, has resided in the United States for a period or periods aggregating 10 years or more or has earned not less than 40 quarters of coverage;

(ii) Except that, effective with the month of July 1968, the provisions of paragraph (b)(2)(i) of this section do not apply if (*a*) the beneficiary is a citizen of a country having a social insurance or pension system which meets the conditions described in paragraphs (b)(7) (i), (ii), and (iii) of this section but does not meet the condition described in paragraph (b)(7)(iv) of this section, or (*b*) the beneficiary is a citizen of a country that has no social insurance or pension system of general application if at any time within 5 years prior to January 1968 (or the first month after December 1967 in which his benefits are subject to suspension pursuant to paragraph (a) of this section) payments to individuals residing in such country were withheld by the Treasury Department under the first section of the Act of October 9, 1940 (31 U.S.C. 123) (see paragraph (c) of this section);

(iii) For purposes of this subparagraph a period of residence begins with the day the insured individual arrives in the United States with the intention of establishing at least a temporary home here; it continues so long as he maintains an attachment to an abode in the United States, accompanied by actual physical presence in the United States for a significant part of the period; and ends with the day of departure from the United States with the intention to reside elsewhere; or

(3) The individual is outside the United States while in the active military or naval service of the United States; or

(4) The individual on whose earnings the benefit is based died before that month and:

(i) Death occurred while the individual was on active duty or inactive duty training as a member of a uniformed service, or

(ii) Death occurred after the individual was discharged or released from a period of active duty or inactive duty training as a member of a uniformed service, and the Administrator of Veterans' Affairs determines, and certifies to the Commissioner, that the discharge or release was under conditions other than dishonorable and that death was as a result of a disease or injury incurred or aggravated in line of duty while on active duty or inactive duty training; or

(5) The individual on whose earnings record the benefit is based worked in service covered by the Railroad Retirement Act, and such work is treated as employment covered by the Social Security Act under the provisions described in subpart O of this part; or

(6) The nonpayment of monthly benefits under the provisions described in paragraph (a) of this section would be contrary to a treaty obligation of the United States in effect on August 1, 1956 (see § 404.463(b)); or

(7) The individual is a citizen of a foreign country that the Commissioner determines has in effect a social insurance or pension system (see § 404.463) which meets all of the following conditions:

(i) Such system pays periodic benefits or the actuarial equivalent thereof; and

(ii) The system is of general application; and

(iii) Benefits are paid in this system on account of old age, retirement, or death; and

(iv) Individuals who are citizens of the United States but not citizens of the foreign country and who qualify for such benefits are permitted to receive benefits without restriction or qualification, at their full rate, or the actuarial equivalent thereof, while outside of the foreign country and without regard to the duration of their absence therefrom.

(c) *Nonpayment of monthly benefits to aliens residing in certain countries*—(1) *Benefits for months after June 1968.* Notwithstanding the provisions of paragraphs (a) and (b) of this section, no monthly benefit may be paid for any month after June 1968 to any individual who is not a citizen or national of the United States for any month such individual resides in a country to which payments to individuals in such country are being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123).

(2) *Benefits for months before July 1968.* If any benefits which an individual who is not a citizen or national of the United States was entitled to receive under title II of the Social Security Act are, on June 30, 1968, being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123), upon removal of the restriction such benefits, payable to such individual for months after the month in which the determination by the Treasury Department that the benefits should be so withheld was made, shall not be paid—

(i) To any person other than such individual, or, if such individual dies before such benefits can be paid, to any person other than an individual who was entitled for the month in which the deceased individual died (with the application of section 202(j)(1) of the Social Security Act) to a monthly benefit under title II of such Act on the basis of the same wages and self-employment income as such deceased individual; or

(ii) In excess of an amount equal to the amount of the last 12 months' benefits that would have been payable to such individual.

(3) *List of countries under Treasury Department alien payment restriction.* Pursuant to the provisions of the first section of the Act of October 9, 1940 (31 U.S.C. 123) the Treasury Department is currently withholding payments to individuals residing in the following countries. Further additions to or deletions from the list of countries will be published in the FEDERAL REGISTER.

Cuba
Democratic Kampuchea (formerly Cambodia)
North Korea
Vietnam

(d) *Nonpayment of monthly benefits to certain aliens entitled to benefits on a worker's earnings record.* An individual who after December 31, 1984 becomes eligible for benefits on the earnings record of a worker for the first time, is an alien, has been outside the United States for more than 6 consecutive months, and is qualified to receive a monthly benefit by reason of the provisions of paragraphs (b)(2), (b)(3), (b)(5), or (b)(7) of this section, must also meet a U.S. residence requirement described in this section to receive benefits:

(1) An alien entitled to benefits as a child of a living or deceased worker—

(i) Must have resided in the U.S. for 5 or more years as the child of the parent on whose earnings record entitlement is based; or

(ii) The parent on whose earnings record the child is entitled and the other parent, if any, must each have either resided in the United States for 5 or more years or died while residing in the U.S.

(2) An alien who meets the requirements for child's benefits based on paragraph (d)(1) of this section above, whose status as a child is based on an adoptive relationship with the living or deceased worker, must also—

(i) Have been adopted within the United States by the worker on whose earnings record the child's entitlement is based; and

(ii) Have lived in the United States with, and received one-half support from, the worker for a period, beginning prior to the child's attainment of age 18, of

(A) At least one year immediately before the month in which the worker became eligible for old-age benefits or

disability benefits or died (whichever occurred first), or

(B) If the worker had a period of disability which continued until the worker's entitlement to old-age or disability benefits or death, at least one year immediately before the month in which that period of disability began.

(3) An alien entitled to benefits as a spouse, surviving spouse, divorced spouse, surviving divorced spouse, or surviving divorced mother or father must have resided in the United States for 5 or more years while in a spousal relationship with the person on whose earnings record the entitlement is based. The spousal relationship over the required period can be that of wife, husband, widow, widower, divorced wife, divorced husband, surviving divorced wife, surviving divorced husband, surviving divorced mother, surviving divorced father, or a combination of two or more of these categories.

(4) An alien who is entitled to parent's benefits must have resided in the United States for 5 or more years as a parent of the person on whose earnings record the entitlement is based.

(5) Individuals eligible for benefits before January 1, 1985 (including those eligible for one category of benefits on a particular worker's earnings record after December 31, 1984, but also eligible for a different category of benefits on the same worker's earnings record before January 1, 1985), will not have to meet the residency requirement.

(6) Definitions applicable to paragraph (d) of this section are as follows:

Eligible for benefits means that an individual satisfies the criteria described in subpart D of this part for benefits at a particular time except that the person need not have applied for those benefits at that time.

Other parent for purposes of paragraph (d)(1)(ii) of this section means any other living parent who is of the opposite sex of the worker and who is the adoptive parent by whom the child was adopted before the child attained age 16 and who is or was the spouse of the person on whose earnings record the child is entitled; or the natural mother or natural father of the child; or the step-parent of the child by a marriage, contracted before the child attained age 16, to the natural or adopting parent on whose earnings record the child is entitled. (Note: Based on this definition, a child may have more than one living *other parent*. However, the child's benefit will be payable for a month if in that month he or she has one *other parent* who had resided in the U.S. for at least 5 years.)

Resided in the United States for satisfying the residency requirement means presence in the United States with the intention of establishing at least a temporary home. A period of residence begins upon arrival in the United States with that intention and continues so long as an attachment to an abode in the United States is maintained, accompanied by actual physical presence in the United States for a significant part of the period, and ending the day of departure from the United States with the intention to reside elsewhere. The period need not have been continuous and the requirement is satisfied if the periods of U.S. residence added together give a total of 5 full years.

(7) The provisions described in paragraph (d) of this section shall not apply if the beneficiary is a citizen or resident of a country with which the United States has a totalization agreement in force, except to the extent provided by that agreement.

[32 FR 19159, Dec. 20, 1967, as amended at 34 FR 13366, Aug. 19, 1969; 52 FR 8249, Mar. 17, 1987; 52 FR 26145, July 13, 1987; 60 FR 17445, Apr. 6, 1995; 62 FR 38450, July 18, 1997]

§ 404.461 Nonpayment of lump sum after death of alien outside United States for more than 6 months.

Where an individual dies outside the United States after January 1957 and no monthly benefit was or could have been paid to him for the month preceding the month in which he died because of the provisions described in § 404.460, no lump-sum death payment may be made upon the basis of the individual's earnings record.

§ 404.462 Nonpayment of hospital and medical insurance benefits of alien outside United States for more than 6 months.

No payments may be made under part A (hospital insurance benefits) of

title XVIII for items or services furnished to an individual in any month for which the prohibition described in § 404.460 against payment of benefits to an individual outside the United States for more than six full consecutive calendar months is applicable (or would be if he were entitled to any such benefits). Also, no payments may be made under part B (supplementary medical insurance benefits) of title XVIII for expenses incurred by an individual during any month the individual is not paid a monthly benefit by reason of the provisions described in § 404.460 or for which no monthly benefit would be paid if he were otherwise entitled thereto.

§ 404.463 Nonpayment of benefits of aliens outside the United States; "foreign social insurance system," and "treaty obligation" exceptions defined.

(a) *Foreign social insurance system exception.* The following criteria are used to evaluate the social insurance or pension system of a foreign country to determine whether the exception described in § 404.460(b) to the alien nonpayment provisions applies:

(1) *Social insurance or pension system.* A *social insurance system* means a governmental plan which pays benefits as an earned right, on the basis either of contributions or work in employment covered under the plan, without regard to the financial need of the beneficiary. However, a plan of this type may still be regarded as a *social insurance system* though it may provide, in a subordinate fashion, for a supplemental payment based on need. A *pension system* means a governmental plan which pays benefits based on residence or age, or a private employer's plan for which the government has set up uniform standards for coverage, contributions, eligibility, and benefit amounts provided that, in both of these types of plans, the financial need of the beneficiary is not a consideration.

(2) *In effect.* The social insurance or pension system of the foreign country must be *in effect.* This means that the foreign social insurance or pension system is in full operation with regard to taxes (or contributions) and benefits, or is in operation with regard to taxes (or contributions), and provision is made for payments to begin immediately upon the expiration of the period provided in the law for acquiring earliest eligibility. It is not *in effect* if the law leaves the beginning of operation to executive or other administrative action; nor is it in effect if the law has been temporarily suspended.

(3) *General application.* The term *of general application* means that the social insurance or pension system (or combination of systems) covers a substantial portion of the paid labor force in industry and commerce, taking into consideration the industrial classification and size of the paid labor force and the population of the country, as well as occupational, size of employer, and geographical limitations on coverage.

(4) *Periodic benefit or actuarial equivalent.* The term *periodic benefit* means a benefit payable at stated regular intervals of time such as weekly, biweekly, or monthly. *Actuarial equivalent* of a periodic benefit means the commutation of the value of the periodic benefit into a lump-sum payment, taking life expectancy and interest into account.

(5) *Benefits payable on account of old age, retirement, or death.* The requirement that benefits be payable *on account of old age, retirement, or death,* is satisfied if the foreign social insurance plan or system includes provision for payment of benefits to aged or retired persons and to dependents and survivors of covered workers. The requirement is also met where the system pays benefits based only on old age or retirement. The requirement is not met where the only benefits payable are workmen's compensation payments, cash sickness payments, unemployment compensation payments, or maternity insurance benefits.

(6) *System under which U.S. citizens who qualify may receive payment while outside the foreign country.* The foreign social insurance or pension system must permit payments to qualified U.S. citizens while outside such foreign country, regardless of the duration of their absence therefrom and must make the payments without restriction or qualification to these U.S. citizens at full rate, or at the full actuarial value. The foreign system is considered to pay benefits at the full rate if the U.S. citizen receives the full benefit

rate in effect for qualified beneficiaries at the time of his award, whether he is then inside or outside the paying country; and he continues to receive the same benefit amount so long as he remains outside that country, even though he may not receive any increases going into effect after his award provided that in those other countries in which such increases are denied to beneficiaries, they are denied to all beneficiaries including nationals of the paying country.

(7) *List of countries which meet the social insurance or pension system exception in section 202(t)(2) of the act.* The following countries have been found to have in effect a social insurance or pension system which meets the requirements of section 202(t)(2) of the Act. Unless otherwise specified, each country meets such requirements effective January 1957. The effect of these findings is that beneficiaries who are citizens of such countries and not citizens of the United States may be paid benefits regardless of the duration of their absence from the United States unless for months beginning after June 1968 they are residing in a country to which payments to individuals are being withheld by the Treasury Department pursuant to the first section of the Act of October 9, 1940 (31 U.S.C. 123). Further additions to or deletions from the list of countries will be published in the FEDERAL REGISTER.

Antigua and Barbuda (effective November 1981)
Argentina (effective July 1968)
Austria (except from January 1958 through June 1961)
Bahamas, Commonwealth of the (effective October 1974)
Barbados (effective July 1968)
Belgium (effective July 1968)
Belize (effective September 1981)
Bolivia
Brazil
Burkina Faso, Republic of (formerly Upper Volta)
Canada (effective January 1966)
Chile
Colombia (effective January 1967)
Costa Rica (effective May 1962)
Cyprus (effective October 1964)
Czechoslovakia (effective July 1968)
Denmark (effective April 1964)
Dominica (effective November 1978)
Dominican Republic (effective November 1984)
Ecuador
El Salvador (effective January 1969)
Finland (effective May 1968)
France (effective June 1968)
Gabon (effective June 1964)
Grenada (effective April 1983)
Guatemala (effective October 1978)
Guyana (effective September 1969)
Iceland (effective December 1980)
Ivory Coast
Jamaica (effective July 1968)
Liechtenstein (effective July 1968)
Luxembourg
Malta (effective September 1964)
Mexico (effective March 1968)
Monaco
Netherlands (effective July 1968)
Nicaragua (effective May 1986)
Norway (effective June 1968)
Panama
Peru (effective February 1969)
Philippines (effective June 1960)
Poland (effective March 1957)
Portugal (effective May 1968)
San Marino (effective January 1965)
Spain (effective May 1966)
St. Christopher and Nevis (effective September 1983)
St. Lucia (effective August 1984)
Sweden (effective July 1966)
Switzerland (effective July 1968)
Trinidad and Tobago (effective July 1975)
Trust Territory of the Pacific Islands (Micronesia) (effective July 1976)
Turkey
United Kingdom
Western Samoa (effective August 1972)
Yugoslavia
Zaire (effective July 1961) (formerly Congo (Kinshasa))

(b) *The ''treaty obligation'' exception.* It is determined that the Treaties of Friendship, Commerce, and Navigation now in force between the United States and the Federal Republic of Germany, Greece, the Republic of Ireland, Israel, Italy, and Japan, respectively, create treaty obligations precluding the application of § 404.460(a) to citizens of such countries; and that the Treaty of Friendship, Commerce, and Navigation now in force between the United States and the Kingdom of the Netherlands creates treaty obligations precluding the application of § 404.460(a) to citizens of that country with respect to monthly survivors benefits only. There is no treaty obligation that would preclude the application of § 404.460(a) to citizens of any country other than those listed above.

[32 FR 19159, Dec. 20, 1967, as amended at 43 FR 2628, Jan. 18, 1978; 52 FR 8249, Mar. 17, 1987]

§ 404.464 Nonpayment of benefits where individual is deported; prohibition against payment of lump sum based on deported individual's earnings records.

(a) *Old-age or disability insurance benefits.* When an individual is deported under the provisions of section 241(a) of the Immigration and Nationality Act (other than under paragraph (1)(C) or (1)(E) thereof), no old-age or disability insurance benefit is payable to the individual for any month occurring after the month in which the Commissioner is notified by the Attorney General of the United States that the individual has been deported and before the month in which the individual is thereafter lawfully admitted to the United States for permanent residence. An individual is considered lawfully admitted for permanent residence as of the month he enters the United States with permission to reside here permanently.

(b) *Other monthly benefits.* If, under the provisions described in paragraph (a) of this section, no old-age or disability insurance benefit is payable to an individual for a month, no monthly insurance benefit is payable for that month, based upon the individual's earnings record, to any other person who is not a citizen of the United States and who is outside the United States for any part of that month.

(c) *Lump sum death payment.* No lump-sum death payment is payable on the basis of the earnings of an individual deported under section 241(a) of the Immigration and Nationality Act (other than paragraph (1)(C) or (1)(E) thereof) if the individual dies in or after the month in which the Commissioner receives notice that he has been deported and before the month in which the individual is thereafter lawfully admitted to the United States for permanent residence.

[32 FR 19159, Dec. 20, 1967, as amended at 58 FR 64889, Dec. 10, 1993; 62 FR 38450, July 18, 1997]

§ 404.465 Conviction for subversive activities; effect on monthly benefits and entitlement to hospital insurance benefits.

(a) *Effect of conviction.* Where an individual is convicted of any offense (committed after August 1, 1956) under chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 U.S.C., or under section 4, 112, or 113 of the Internal Security Act of 1950, as amended, the court, in addition to all other penalties provided by law, may order that, in determining whether any monthly benefit is payable to the individual for the month in which he is convicted or for any month thereafter, and in determining whether the individual is entitled to hospital insurance benefits under part A of title XVIII for any such month, and in determining the amount of the benefit for that month, the following are not to be taken into account:

(1) Any wages paid to such individual, or to any other individual, in the calendar quarter in which such conviction occurred or in any prior calendar quarter, and

(2) Any net earnings from self-employment derived by the individual, or any other individual, during the taxable year in which the conviction occurred or during any prior taxable year.

(b) *Recalculation of benefit.* When notified by the Attorney General that the additional penalty as described in paragraph (a) of this section has been imposed against any individual entitled to benefits under section 202 or section 223 of the Act (see subpart D), the Administration, for the purposes of determining the individual's entitlement to such benefits as of the month in which convicted and the amount of the benefit, will exclude the applicable wages and net earnings in accordance with the order of the court.

(c) *Effect of pardon.* In the event that an individual, with respect to whom the additional penalty as described in paragraph (a) of this section has been imposed, is granted a pardon of the offense by the President of the United States, such penalty is not applied in determining such individual's entitlement to benefits, and the amount of such benefit, for any month beginning after the date on which the pardon is granted.

§ 404.466 Conviction for subversive activities; effect on enrollment for supplementary medical insurance benefits.

An individual may not enroll under part B (supplementary medical insurance benefits) of title XVIII if he has been convicted of any offense described in § 404.465.

§ 404.467 Nonpayment of benefits; individual entitled to disability insurance benefits or childhood disability benefits based on statutory blindness is engaging in substantial gainful activity.

(a) *Disability insurance benefits.* An individual who has attained age 55 and who meets the definition of disability for disability insurance benefits purposes based on *statutory blindness,* as defined in § 404.1581, may be entitled to disability insurance benefits for months in which he is engaged in certain types of substantial gainful activity. No payment, however, may be made to the individual or to beneficiaries entitled to benefits on his earnings record for any month in which such individual engages in any type of substantial gainful activity.

(b) *Childhood disability benefits.* An individual who has attained age 55 and who meets the definition of disability prescribed in § 404.1583 for childhood disability benefits on the basis of statutory blindness may be entitled to childhood disability benefits for months in which he engages in certain types of substantial gainful activity. However, no payment may be made to such individual for any month after December 1972 in which such individual engages in substantial gainful activity.

[39 FR 43715, Dec. 18, 1974, as amended at 51 FR 10616, Mar. 28, 1986]

§ 404.468 Nonpayment of benefits to prisoners.

(a) *General.* No monthly benefits will be paid to any individual for any month any part of which the individual is confined in a jail, prison, or other penal institution or correctional facility for conviction of a felony. This rule applies to disability benefits (§ 404.315) and child's benefits based on disability (§ 404.350) effective with benefits payable for months beginning on or after October 1, 1980. For all other monthly benefits, this rule is effective with benefits payable for months beginning on or after May 1, 1983. However, it applies only to the prisoner; benefit payments to any other person who is entitled on the basis of the prisoner's wages and self-employment income are payable as though the prisoner were receiving benefits.

(b) *Felonious offenses.* An offense will be considered a felony if—

(1) It is a felony under applicable law: or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(c) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as the individual is under a sentence of confinement and has not been released due to parole or pardon. An individual is considered confined even though he or she is temporarily or intermittently outside of that facility (e.g., on work release, attending school, or hospitalized).

(d) *Vocational rehabilitation exception.* The nonpayment provision of paragraph (a) of this section does not apply if a prisoner who is entitled to benefits on the basis of disability is actively and satisfactorily participating in a rehabilitation program which has been specifically approved for the individual by court of law. In addition, the Commissioner must determine that the program is expected to result in the individual being able to do substantial gainful activity upon release and within a reasonable time. No benefits will be paid to the prisoner for any month prior to the approval of the program.

[49 FR 48182, Dec. 11, 1984, as amended at 62 FR 38450, July 18, 1997]

§ 404.469 Nonpayment of benefits where individual has not furnished or applied for a Social Security number.

No monthly benefits will be paid to an entitled individual unless he or she

either furnishes to the Social Security Administration (SSA) satisfactory proof of his or her Social Security number, or, if the individual has not been assigned a number, he or she makes a proper application for a number (see § 422.103). An individual submits satisfactory proof of his or her Social Security number by furnishing to SSA the number and sufficient additional information that can be used to determine whether that Social Security number or another number has been assigned to the individual. Sufficient additional information may include the entitled individual's date and place of birth, mother's maiden name, and father's name. If the individual does not know his or her Social Security number, SSA will use this additional information to determine the Social Security number, if any, that it assigned to the individual. This rule applies to individuals who become entitled to benefits beginning on or after June 1, 1989.

[56 FR 41789, Aug. 23, 1991]

§ 404.470 Nonpayment of disability benefits due to noncompliance with rules regarding treatment for drug addiction or alcoholism.

(a) *Suspension of monthly benefits.* (1) For an individual entitled to benefits based on a disability (§ 404.1505) and for whom drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), monthly benefits will be suspended beginning with the first month after we notify the individual in writing that he or she has been determined not to be in compliance with the treatment requirements for such individuals (§ 404.1536).

(2) This rule applies to all individuals entitled to disability benefits (§ 404.315), widow(er)'s benefits (§ 404.335), and child's benefits based on a disability (§ 404.350) effective with benefits paid in months beginning on or after March 1, 1995.

(3) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

(b) *Resumption of monthly benefits.* The payment of benefits may be resumed only after an individual demonstrates and maintains compliance with appropriate treatment requirements for:

(1) 2 consecutive months for the first determination of noncompliance;

(2) 3 consecutive months for the second determination of noncompliance; and

(3) 6 consecutive months for the third and all subsequent determinations of noncompliance.

(c) *Termination of benefits.* (1) A suspension of benefit payments due to noncompliance with the treatment requirements for 12 consecutive months will result in termination of benefits effective with the first month following the 12th month of suspension of benefits.

(2) Benefit payments to any other person who is entitled on the basis of a disabled wage earner's entitlement to disability benefits are payable as though the disabled wage earner were receiving benefits.

[60 FR 8146, Feb. 10, 1995]

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

(a) *General.* For disabled beneficiaries who receive benefit payments through a representative payee because drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), certain amounts due the beneficiary for a past period will be paid in installments. The amounts subject to payment in installments include:

(1) Benefits due but unpaid which accrued prior to the month payment was effectuated;

(2) Benefits due but unpaid which accrued during a period of suspension for which the beneficiary was subsequently determined to have been eligible; and

(3) Any adjustment to benefits which results in an accrual of unpaid benefits.

(b) *Installment formula.* Except as provided in paragraph (c) of this section, the amount of the installment payment in any month is limited so that the sum of (1) the amount due for a

past period (and payable under paragraph (a) of this section) paid in such month and (2) the amount of any benefit due for the preceding month under such entitlement which is payable in such month, does not exceed two times the amount of the beneficiary's benefit payment for the preceding month. In counting the amount of the beneficiary's benefit payment for the previous month, no reductions or deductions under this title are taken into account.

(c) *Exception to installment limitation.* An exception to the installment payment limitation in paragraph (b) of this section can be granted for the first month in which a beneficiary accrues benefit amounts subject to payment in installments if the beneficiary has unpaid housing expenses which result in a high risk of homelessness for the beneficiary. In that case, the benefit payment may be increased by the amount of the unpaid housing expenses so long as that increase does not exceed the amount of benefits which accrued during the most recent period of nonpayment. We consider a person to be at risk of homelessness if continued nonpayment of the outstanding housing expenses is likely to result in the person losing his or her place to live or if past nonpayment of housing expenses has resulted in the person having no appropriate personal place to live. In determining whether this exception applies, we will ask for evidence of outstanding housing expenses that shows that the person is likely to lose or has already lost his or her place to live. For purposes of this section, homelessness is the state of not being under the control of any public institution and having no appropriate personal place to live. Housing expenses include charges for all items required to maintain shelter (for example, mortgage payments, rent, heating fuel, and electricity).

(d) *Payment through a representative payee.* If the beneficiary does not have a representative payee, payment of amounts subject to installments cannot be made until a representative payee is selected.

(e) *Underpaid beneficiary no longer entitled.* In the case of a beneficiary who is no longer currently entitled to monthly payments, but to whom amounts defined in paragraph (a) of this section are still owing, we will treat such beneficiary's monthly benefit for the last month of entitlement as the beneficiary's benefit for the preceding month and continue to make installment payments of such benefits through a representative payee.

(f) *Beneficiary currently not receiving Social Security benefits because of suspension for noncompliance with treatment.* If a beneficiary is currently not receiving benefits because his or her benefits have been suspended for noncompliance with treatment (as defined in § 404.1536), the payment of amounts under paragraph (a) of this section will stop until the beneficiary has demonstrated compliance with treatment as described in § 404.470 and will again commence with the first month the beneficiary begins to receive benefit payments.

(g) *Underpaid beneficiary deceased.* Upon the death of a beneficiary, any remaining unpaid amounts as defined in paragraph (a) of this section will be treated as underpayments in accordance with § 404.503(b).

[60 FR 8146, Feb. 10, 1995]

Subpart F—Overpayments, Underpayments, Waiver of Adjustment or Recovery of Overpayments, and Liability of a Certifying Officer

AUTHORITY: Secs. 204, 205(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 404, 405(a), and 902(a)); 31 U.S.C. 3720A.

§ 404.501 General applicability of section 204 of the Act.

(a) *In general.* Section 204 of the Act provides for adjustment as set forth in §§ 404.502 and 404.503, in cases where an individual has received more or less than the correct payment due under title II of the Act. As used in this subpart, the term *overpayment* includes a payment in excess of the amount due under title II of the Act, a payment resulting from the failure to impose deductions or to suspend or reduce benefits under sections 203, 222(b), 224, and 228(c), and (d), and (e) of the Act (see subpart E of this part), a payment pursuant to section 205(n) of the Act in an

amount in excess of the amount to which the individual is entitled under section 202 or 223 of the Act, a payment resulting from the failure to terminate benefits, and a payment where no amount is payable under title II of the Act. The term *underpayment* as used in this subpart refers only to monthly insurance benefits and includes nonpayment where some amount of such benefits was payable. An underpayment may be in the form of an accrued unpaid benefit amount for which no check has been drawn or in the form of an unnegotiated check payable to a deceased individual. The provisions for adjustment also apply in cases where through error:

(1) A reduction required under section 202(j)(1), 202(k)(3), 203(a), or 205(n) of the Act is not made, or

(2) An increase or decrease required under section 202(d)(2), or 215 (f) or (g) of the Act is not made, or

(3) A deduction required under section 203(b) (as may be modified by the provisions of section 203(h)), 203(c), 203(d), 203(i), 222(b), or 223(a)(1)(D) of the Act or section 907 of the Social Security Amendments of 1939 is not made, or

(4) A suspension required under section 202(n) or 202(t) of the Act is not made, or

(5) A reduction under section 202(q) of the Act is not made, or

(6) A reduction, increase, deduction, or suspension is made which is either more or less than required, or

(7) A payment in excess of the amount due under title XVIII of the Act was made to or on behalf of an individual (see 42 CFR 405.350 through 405.351) entitled to benefits under title II of the Act, or

(8) A payment of past due benefits is made to an individual and such payment had not been reduced by the amount of attorney's fees payable directly to an attorney under section 206 of the Act (see § 404.977).

(9) A reduction under § 404.408b is made which is either more or less than required.

(b) *Payments made on the basis of an erroneous report of death.* Any monthly benefit or lump sum paid under title II of the Act on the basis of an erroneous report by the Department of Defense of the death of an individual in the line of duty while such individual was a member of the uniformed services (as defined in section 210(m) of the Act) on active duty (as defined in section 210(l) of the Act) is deemed a correct payment for any month prior to the month such Department notifies the Administration that such individual is alive.

(c) *Payments made by direct deposit to a financial institution.* When a payment in excess of the amount due under title II of the Act is made by direct deposit to a financial institution to or on behalf of an individual who has died, and the financial institution credits the payment to a joint account of the deceased individual and another person who was entitled to a monthly benefit on the basis of the same earnings record as the deceased individual for the month before the month in which the deceased individual died, the amount of the payment in excess of the correct amount will be an overpayment to the other person.

[34 FR 14887, Sept. 27, 1969, as amended at 44 FR 34942, June 18, 1979; 47 FR 4988, Feb. 3, 1982; 48 FR 46149, Oct. 11, 1983; 55 FR 7313, Mar. 1, 1990]

§ 404.502 Overpayments.

Upon determination that an overpayment has been made, adjustments will be made against monthly benefits and lump sums as follows:

(a) *Individual overpaid is living.* (1) If the individual to whom an overpayment was made is at the time of a determination of such overpayment entitled to a monthly benefit or a lump sum under title II of the Act, or at any time thereafter becomes so entitled, no benefit for any month and no lump sum is payable to such individual, except as provided in paragraphs (c) and (d) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded. Such adjustments will be made against any monthly benefit or lump sum under title II of the Act to which such individual is entitled whether payable on the basis of such individual's earnings or the earnings of another individual.

(2) If any other individual is entitled to benefits for any month on the basis of the same earnings as the overpaid individual, except as adjustment is to

be effected pursuant to paragraphs (c) and (d) of this section by withholding a part of the monthly benefit of either the overpaid individual or any other individual entitled to benefits on the basis of the same earnings, no benefit for any month will be paid on such earnings to such other individual until an amount equal to the amount of the overpayment has been withheld or refunded.

(b) *Individual overpaid dies before adjustment.* If an overpaid individual dies before adjustment is completed under the provisions of paragraph (a) of this section, no lump sum and no subsequent monthly benefit will be paid on the basis of earnings which were the basis of the overpayment to such deceased individual until full recovery of the overpayment has been effected, except as provided in paragraphs (c) and (d) of this section or under §404.515. Such recovery may be effected through:

(1) Payment by the estate of the deceased overpaid individual,

(2) Withholding of amounts due the estate of such individual under title II of the Act,

(3) Withholding a lump sum or monthly benefits due any other individual on the basis of the same earnings which were the basis of the overpayment to the deceased overpaid individual, or

(4) Any combination of the amount above.

(c) *Adjustment by withholding part of a monthly benefit.* (1) Where it is determined that withholding the full amount each month would *defeat the purpose of title II,* i.e., deprive the person of income required for ordinary and necessary living expenses (see §404.508), adjustment under paragraphs (a) and (b) of this section may be effected by withholding an amount of not less than $10 of the monthly benefit payable to an individual.

(2) Adjustment as provided by this paragraph will not be available if the overpayment was caused by the individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information. In such cases, recovery of the overpayment will be accomplished as provided in paragraph (a) of this section.

(d) *Individual overpaid enrolled under supplementary insurance plan.* Notwithstanding the provisions of paragraphs (a), (b), and (c) of this section, if the individual liable for the overpayment is an enrollee under part B of title XVIII of the Act and the overpayment was not caused by such individual's intentional false statement or representation, or willful concealment of, or deliberate failure to furnish, material information, an amount of such individual's monthly benefit which is equal to his obligation for supplementary medical insurance premiums will be applied toward payment of such premiums, and the balance of the monthly benefit will be applied toward recovery of the overpayment. Further adjustment with respect to such balance may be made if the enrollee so requests and meets the conditions of paragraph (c) of this section.

[35 FR 5943, Apr. 10, 1970, as amended at 44 FR 20653, Apr. 6, 1979]

§404.502a Notice of right to waiver consideration.

Whenever an initial determination is made that more than the correct amount of payment has been made, and we seek adjustment or recovery of the overpayment, the individual from whom we are seeking adjustment or recovery is immediately notified. The notice includes:

(a) The overpayment amount and how and when it occurred;

(b) A request for full, immediate refund, unless the overpayment can be withheld from the next month's benefit;

(c) The proposed adjustment of benefits if refund is not received within 30 days after the date of the notice and adjustment of benefits is available;

(d) An explanation of the availability of a different rate of withholding when full withholding is proposed, installment payments when refund is requested and adjustment is not currently available, and/or cross-program recovery when refund is requested and the individual is receiving another type of payment from SSA (language about cross-program recovery is not included

in notices sent to individuals in jurisdictions where this recovery option is not available);

(e) An explanation of the right to request waiver of adjustment or recovery and the automatic scheduling of a file review and pre-recoupment hearing (commonly referred to as a personal conference) if a request for waiver cannot be approved after initial paper review;

(f) An explanation of the right to request reconsideration of the fact and/or amount of the overpayment determination;

(g) Instructions about the availability of forms for requesting reconsideration and waiver;

(h) An explanation that if the individual does not request waiver or reconsideration within 30 days of the date of the overpayment notice, adjustment or recovery of the overpayment will begin;

(i) A statement that an SSA office will help the individual complete and submit forms for appeal or waiver requests; and

(j) A statement that the individual receiving the notice should notify SSA promptly if reconsideration, waiver, a lesser rate of withholding, repayment by installments or cross-program adjustment is wanted.

[61 FR 56131, Oct. 31, 1996]

§ 404.503 Underpayments.

Underpayments will be adjusted as follows:

(a) *Individual underpaid is living.* If an individual to whom an underpayment is due is living, the amount of such underpayment will be paid to such individual either in a single payment (if he is not entitled to a monthly benefit or a lump-sum death payment) or by increasing one or more monthly benefits or a lump-sum death payment to which such individual is or becomes entitled.

(b) *Individual dies before adjustment of underpayment.* If an individual to whom an underpayment is due dies before receiving payment or negotiating a check or checks representing such payment, such underpayment will be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse as defined in section 216(c), (g), or (h) of the Act who was either:

(i) Living in the same household (as defined in § 404.347) with the deceased individual at the time of such individual's death, or

(ii) Entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died.

(2) The child or children of the deceased individual (as defined in section 216 (e) or (h) of the Act) entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such child, in equal shares to each such child).

(3) The parent or parents of the deceased individual, entitled to a monthly benefit on the basis of the same earnings record as was the deceased individual for the month in which such individual died (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(4) The surviving spouse of the deceased individual (as defined in section 216(c), (g), or (h) of the Act) who does not qualify under paragraph (b)(1) of this section.

(5) The child or children of the deceased individual (as defined in section 216 (e) or (h) of the Act) who do not qualify under paragraph (b)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual, who do not qualify under paragraph (b)(3) of this section (if more than one such parent, in equal shares to each such parent). For this purpose, the definition of ''parent'' in § 404.374 includes the parent(s) of any deceased individual who was entitled to benefits under title II of the Act.

(7) The legal representative of the estate of the deceased individual as defined in paragraph (d) of this section.

(c) In the event that a person who is otherwise qualified to receive an underpayment under the provisions of

paragraph (b) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his share of the underpayment will be divided among the remaining living person(s) in the same order of priority. In the event that there is (are) no other such person(s), the underpayment will be paid to the living person(s) in the next lower order of priority under paragraph (b) of this section.

(d) *Definition of legal representative.* The term *legal representative,* for the purpose of qualifying to receive an underpayment, generally means the administrator or executor of the estate of the deceased individual. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided that such person can give the Administration good acquittance (as defined in paragraph (e) of this section). The following persons may qualify as legal representative for the purposes of this subpart, provided they can give the Administration good acquittance:

(1) A person who qualifies under a State's *small estate* statute,

(2) A person resident in a foreign country who, under the laws and customs of that country, has the right to receive assets of the estate,

(3) A public administrator, or

(4) A person who has the authority, under applicable law, to collect the assets of the estate of the deceased individual.

(e) *Definition of ''good acquittance.''* A person is considered to give the Administration *good acquittance* when payment to that person will release the Administration from further liability for such payment.

[34 FR 14487, Sept. 27, 1969, as amended at 35 FR 14129, Sept. 5, 1970; 55 FR 7313, Mar. 1, 1990; 60 FR 17445, Apr. 6, 1995]

§ 404.504 Relation to provisions for reductions and increases.

The amount of an overpayment or underpayment is the difference between the amount paid to the beneficiary and the amount of the payment to which the beneficiary was actually entitled. Such payment, for example, would be equal to the difference between the amount of a benefit in fact paid to the beneficiary and the amount of such benefit as reduced under section 202(j)(1), 202(k)(3), 203(a), or 224(a), or as increased under section 202(d)(2), 202(m), or 215 (f) and (g). In effecting an adjustment with respect to an overpayment, no amount can be considered as having been withheld from a particular benefit which is in excess of the amount of such benefit as so decreased.

[34 FR 14888, Sept. 27, 1969]

§ 404.505 Relationship to provisions requiring deductions.

Adjustments required by any of the provisions in this subpart F are made in addition to, but after, any deductions required by section 202(t), 203(b), 203(c), 203(d), and 222(b) of the Act, or section 907 of the Social Security Act Amendments of 1939, and before any deductions required by section 203(g) or 203(h)(2) of the Act.

[34 FR 14888, Sept. 27, 1969]

§ 404.506 When waiver may be applied and how to process the request.

(a) Section 204(b) of the Act provides that there shall be no adjustment or recovery in any case where an overpayment under title II has been made to an individual who is without fault if adjustment or recovery would either defeat the purpose of title II of the Act, or be against equity and good conscience.

(b) If an individual requests waiver of adjustment or recovery of a title II overpayment within 30 days after receiving a notice of overpayment that contains the information in § 404.502a, no adjustment or recovery action will be taken until after the initial waiver determination is made. If the individual requests waiver more than 30 days after receiving the notice of overpayment, SSA will stop any adjustment or recovery actions until after the initial waiver determination is made.

(c) When waiver is requested, the individual gives SSA information to support his/her contention that he/she is without fault in causing the overpayment (see § 404.507) and that adjustment or recovery would either defeat the purpose of title II of the Act (see § 404.508) or be against equity and good

conscience (see § 404.509). That information, along with supporting documentation, is reviewed to determine if waiver can be approved. If waiver cannot be approved after this review, the individual is notified in writing and given the dates, times and place of the file review and personal conference; the procedure for reviewing the claims file prior to the personal conference; the procedure for seeking a change in the scheduled dates, times, and/or place; and all other information necessary to fully inform the individual about the personal conference. The file review is always scheduled at least 5 days before the personal conference.

(d) At the file review, the individual and the individual's representative have the right to review the claims file and applicable law and regulations with the decisionmaker or another SSA representative who is prepared to answer questions. We will provide copies of material related to the overpayment and/or waiver from the claims file or pertinent sections of the law or regulations that are requested by the individual or the individual's representative.

(e) At the personal conference, the individual is given the opportunity to:

(1) Appear personally, testify, cross-examine any witnesses, and make arguments;

(2) Be represented by an attorney or other representative (see § 404.1700), although the individual must be present at the conference; and

(3) Submit documents for consideration by the decisionmaker.

(f) At the personal conference, the decisionmaker:

(1) Tells the individual that the decisionmaker was not previously involved in the issue under review, that the waiver decision is solely the decisionmaker's, and that the waiver decision is based only on the evidence or information presented or reviewed at the conference;

(2) Ascertains the role and identity of everyone present;

(3) Indicates whether or not the individual reviewed the claims file;

(4) Explains the provisions of law and regulations applicable to the issue;

(5) Briefly summarizes the evidence already in file which will be considered;

(6) Ascertains from the individual whether the information presented is correct and whether he/she fully understands it;

(7) Allows the individual and the individual's representative, if any, to present the individual's case;

(8) Secures updated financial information and verification, if necessary;

(9) Allows each witness to present information and allows the individual and the individual's representative to question each witness;

(10) Ascertains whether there is any further evidence to be presented;

(11) Reminds the individual of any evidence promised by the individual which has not been presented;

(12) Lets the individual and the individual's representative, if any, present any proposed summary or closing statement;

(13) Explains that a decision will be made and the individual will be notified in writing; and

(14) Explains repayment options and further appeal rights in the event the decision is adverse to the individual.

(g) SSA issues a written decision to the individual (and his/her representative, if any) specifying the findings of fact and conclusions in support of the decision to approve or deny waiver and advising of the individual's right to appeal the decision. If waiver is denied, adjustment or recovery of the overpayment begins even if the individual appeals.

(h) If it appears that the waiver cannot be approved, and the individual declines a personal conference or fails to appear for a second scheduled personal conference, a decision regarding the waiver will be made based on the written evidence of record. Reconsideration is then the next step in the appeals process (but see § 404.930(a)(7)).

[61 FR 56131, Oct. 31, 1996]

§ 404.507 Fault.

Fault as used in *without fault* (see § 404.506 and 42 CFR 405.355) applies only to the individual. Although the Administration may have been at fault in making the overpayment, that fact does not relieve the overpaid individual

or any other individual from whom the Administration seeks to recover the overpayment from liability for repayment if such individual is not without fault. In determining whether an individual is at fault, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. What constitutes fault (except for *deduction overpayments*—see § 404.510) on the part of the overpaid individual or on the part of any other individual from whom the Administration seeks to recover the overpayment depends upon whether the facts show that the incorrect payment to the individual or to a provider of services or other person, or an incorrect payment made under section 1814(e) of the Act, resulted from:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect.

[34 FR 14888, Sept. 27, 1969; 34 FR 15646, Oct. 9, 1969, as amended at 44 FR 34942, June 18, 1979; 59 FR 1634, Jan. 12, 1994]

§ 404.508 Defeat the purpose of Title II.

(a) *General. Defeat the purpose of title II,* for purposes of this subpart, means defeat the purpose of benefits under this title, i.e., to deprive a person of income required for ordinary and necessary living expenses. This depends upon whether the person has an income or financial resources sufficient for more than ordinary and necessary needs, or is dependent upon all of his current benefits for such needs. An individual's ordinary and necessary expenses include:

(1) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance including premiums for supplementary medical insurance benefits under title XVIII), taxes, installment payments, etc.;

(2) Medical, hospitalization, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Other miscellaneous expenses which may reasonably be considered as part of the individual's standard of living.

(b) *When adjustment or recovery will defeat the purpose of title II.* Adjustment or recovery will defeat the purposes of title II in (but is not limited to) situations where the person from whom recovery is sought needs substantially all of his current income (including social security monthly benefits) to meet current ordinary and necessary living expenses.

[32 FR 18026, Dec. 16, 1967, as amended at 34 FR 14888, Sept. 27, 1969]

§ 404.509 Against equity and good conscience; defined.

(a) Recovery of an overpayment is *against equity and good conscience* (under title II and title XVIII) if an individual—

(1) Changed his or her position for the worse (Example 1) or relinquished a valuable right (Example 2) because of reliance upon a notice that a payment would be made or because of the overpayment itself; or

(2) Was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment (Examples 3 and 4).

(b) The individual's financial circumstances are not material to a finding of *against equity and good conscience.*

Example 1. A widow, having been awarded benefits for herself and daughter, entered her daughter in private school because the monthly benefits made this possible. After the widow and her daughter received payments for almost a year, the deceased worker was found to be not insured and all payments to the widow and child were incorrect. The widow has no other funds with which to pay the daughter's private school expenses. Having entered the daughter in private school and thus incurred a financial obligation toward which the benefits had been applied, she was in a worse position financially than if she and her daughter had never been

entitled to benefits. In this situation, the recovery of the payments would be *against equity and good conscience.*

Example 2. After being awarded old-age insurance benefits, an individual resigned from employment on the assumption he would receive regular monthly benefit payments. It was discovered 3 years later that (due to a Social Security Administration error) his award was erroneous because he did not have the required insured status. Due to his age, the individual was unable to get his job back and could not get any other employment. In this situation, recovery of the overpayments would be *against equity and good conscience* because the individual gave up a valuable right.

Example 3. M divorced K and married L. M died a few years later. When K files for benefits as a surviving divorced wife, she learns that L had been overpaid $3,200 on M's earnings record. Because K and L are both entitled to benefits on M's record of earnings and we could not recover the overpayment from L, we sought recovery from K. K was living in a separate household from L at the time of the overpayment and did not receive the overpayment. K requests waiver of recovery of the $3,200 overpayment from benefits due her as a surviving divorced wife of M. In this situation, it would be *against equity and good conscience* to recover the overpayment from K.

Example 4. G filed for and was awarded benefits. His daughter, T, also filed for student benefits on G's earnings record. Since T was an independent, full-time student living in another State, she filed for benefits on her own behalf. Later, after T received 12 monthly benefits, the school reported that T had been a full-time student only 2 months and had withdrawn from school. Since T was overpaid 10 monthly benefits, she was requested to return the overpayment to SSA. T did not return the overpayment and further attempts to collect the overpayment were unsuccessful. G was asked to repay the overpayment because he was receiving benefits on the same earnings record. G requested waiver. To support his waiver request G established that he was not at fault in causing the overpayment because he did not know that T was receiving benefits. Since G is without fault and, in addition, meets the requirements of not living in the same household at the time of the overpayment and did not receive the overpayment, it would be *against equity and good conscience* to recover the overpayment from G.

[53 FR 25483, July 7, 1988]

§ 404.510 When an individual is "without fault" in a deduction overpayment.

In determining whether an individual is ''without fault'' with respect to a deduction overpayment, the Social Security Administration will consider all pertinent circumstances, including the individual's age and intelligence, and any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual has. Except as provided in § 404.511 or elsewhere in this subpart F, situations in which an individual will be considered to be ''without fault'' with respect to a deduction overpayment include, but are not limited to, those that are described in this section. An individual will be considered ''without fault'' in accepting a payment which is incorrect because he/she failed to report an event specified in sections 203 (b) and (c) of the Act, or an event specified in section 203(d) of the Act as in effect for monthly benefits for months after December 1960, or because a deduction is required under section 203 (b), (c), (d), or section 222(b) of the Act, or payments were not withheld as required by section 202(t) or section 228 of the Act, if it is shown that such failure to report or acceptance of the overpayment was due to one of the following circumstances:

(a) Reasonable belief that only his net cash earnings (*take-home* pay) are included in determining the annual earnings limitation or the monthly earnings limitation under section 203(f) of the Act.

(b) Reliance upon erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II of the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto. For example, this circumstance could occur where the individual is misinformed by such source as to the interpretation of a provision in the Act or regulations relating to deductions, or relating to the effect of residence of an alien outside the United States for more than 6 months.

(c) The beneficiary's death caused the earnings limit applicable to his earnings for purposes of deduction and the

charging of excess earnings to be reduced below $1,680 for a taxable year ending after 1967.

(d) [Reserved]

(e) Reasonable belief that in determining, for deduction purposes, his earnings from employment and/or net earnings from self-employment in the taxable year in which he became entitled to benefits, earnings in such year prior to such entitlement would be excluded. However, this provision does not apply if his earnings in the taxable year, beginning with the first month of entitlement, exceeded the earnings limitation amount for such year.

(f) Unawareness that his earnings were in excess of the earnings limitation applicable to the imposition of deductions and the charging of excess earnings or that he should have reported such excess where these earnings were greater than anticipated because of:

(1) Retroactive increases in pay, including back-pay awards;

(2) Work at a higher pay rate than realized;

(3) Failure of the employer of an individual unable to keep accurate records to restrict the amount of earnings or the number of hours worked in accordance with a previous agreement with such individual;

(4) The occurrence of five Saturdays (or other work days, e.g., five Mondays) in a month and the earnings for the services on the fifth Saturday or other work day caused the deductions.

(g) The continued issuance of benefit checks to him after he sent notice to the Administration of the event which caused or should have caused the deductions provided that such continued issuance of checks led him to believe in good faith that he was entitled to checks subsequently received.

(h) Lack of knowledge that bonuses, vacation pay, or similar payments, constitute earnings for purposes of the annual earnings limitation.

(i) [Reserved]

(j) Reasonable belief that earnings in excess of the earnings limitation amount for the taxable year would subject him to deductions only for months beginning with the first month in which his earnings exceeded the earnings limitation amount. However, this provision is applicable only if he reported timely to the Administration during the taxable year when his earnings reached the applicable limitation amount for such year.

(k) Lack of knowledge by a wife, husband, or child entitled to wife's, husband's, or child's insurance benefits, as the case may be, that the individual entitled to old-age insurance benefits on the same earnings record has incurred or would incur deductions because of a violation of the annual earnings or 7–day foreign work test, whichever is applicable, provided the wife, husband, or child is not living with such old-age insurance beneficiary and did not know and had no reason to know that such beneficiary's earnings activity or the income derived therefrom has caused or would cause such deductions.

(l) Reasonable belief, with respect to earnings activity for months after December 1982, that net earnings from self-employment after attainment of age 70 (age 72 for months after December 1972 and before January 1983) in the taxable year in which such age was attained would not cause deductions (see § 404.430(a)) with respect to benefits payable for months in that taxable year prior to the attainment of such age.

(m) Reasonable belief by an individual entitled to child's, wife's, husband's, widow's, widower's, mother's, or parent's insurance benefits that earnings from employment and/or net earnings from self-employment after the termination of entitlement (other than termination by reason of entitlement to an old-age insurance benefit) in the taxable year in which the termination event occurred would not cause deductions with respect to benefits payable for months in that taxable year prior to the month in which the termination event occurred.

(n) Failure to understand the deduction provisions of the Act or the occurrence of unusual or unavoidable circumstances the nature of which clearly shows that the individual was unaware

of a violation of such deduction provisions.

[27 FR 1162, Feb. 8, 1962, as amended at 28 FR 14492, Dec. 31, 1963; 34 FR 14888, Sept. 27, 1969; 36 FR 23361, Dec. 9, 1971; 43 FR 31318, July 21, 1978; 44 FR 20653, Apr. 6, 1979; 59 FR 1634, Jan. 12, 1994; 60 FR 17445, Apr. 6, 1995]

§ 404.510a When an individual is "without fault" in an entitlement overpayment.

A benefit payment under title II or title XVIII of the Act to or on behalf of an individual who fails to meet one or more requirements for entitlement to such payment or a benefit payment exceeding the amount to which he is entitled, constitutes an entitlement overpayment. Where an individual or other person on behalf of an individual accepts such overpayment because of reliance on erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under title II or title XVIII of the Act) with respect to the interpretation of a pertinent provision of the Social Security Act or regulations pertaining thereto, or where an individual or other person on behalf of an individual is overpaid as a result of the adjustment upward (under the family maximum provision in section 203 of the Act) of the benefits of such individual at the time of the proper termination of one or more beneficiaries on the same social security record and the subsequent reduction of the benefits of such individual caused by the reentitlement of the terminated beneficiary(ies) pursuant to a change in a provision of the law, such individual, in accepting such overpayment, will be deemed to be *without fault.* For purposes of this section *governmental agency* includes intermediaries and carriers under contract pursuant to sections 1816 and 1842 of the Act.

[39 FR 43716, Dec. 18, 1974]

§ 404.511 When an individual is at "fault" in a deduction overpayment.

(a) *Degree of care.* An individual will not be *without fault* if the Administration has evidence in its possession which shows either a lack of good faith or failure to exercise a high degree of care in determining whether circumstances which may cause deductions from his benefits should be brought to the attention of the Administration by an immediate report or by return of a benefit check. The high degree of care expected of an individual may vary with the complexity of the circumstances giving rise to the overpayment and the capacity of the particular payee to realize that he is being overpaid. Accordingly, variances in the personal circumstances and situations of individual payees are to be considered in determining whether the necessary degree of care has been exercised by an individual to warrant a finding that he was without fault in accepting a *deduction overpayment.*

(b) *Subsequent deduction overpayments.* The Social Security Administration generally will not find an individual to be without fault where, after having been exonerated for a ''deduction overpayment'' and after having been advised of the correct interpretation of the deduction provision, the individual incurs another ''deduction overpayment'' under the same circumstances as the first overpayment. However, in determining whether the individual is without fault, the Social Security Administration will consider all of the pertinent circumstances surrounding the prior and subsequent ''deduction overpayments,'' including any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which the individual may have.

[16 FR 13054, Dec. 28, 1951, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.512 When adjustment or recovery of an overpayment will be waived.

(a) *Adjustment or recovery deemed ''against equity and good conscience.''* In the situations described in §§ 404.510(a), (b), and (c), and 404.510a, adjustment or recovery will be waived since it will be deemed such adjustment or recovery is *against equity and good conscience.* Adjustment or recovery will also be deemed *against equity and good conscience* in the situation described in § 404.510(e), but only as to a month in which the individual's earnings from

wages do not exceed the total monthly benefits affected for that month.

(b) *Adjustment or recovery considered to defeat the purpose of title II* or be *against equity and good conscience* under certain circumstances. In the situation described in § 404.510(e) (except in the case of an individual whose monthly earnings from wages in employment do not exceed the total monthly benefits affected for a particular month), and in the situations described in § 404.510 (f) through (n), adjustment or recovery shall be waived only where the evidence establishes that adjustment or recovery would work a financial hardship (see § 404.508) or would otherwise be inequitable (see § 404.509).

[27 FR 1163, Feb. 8, 1962, as amended at 35 FR 6321, Apr. 18, 1970; 36 FR 23361, Dec. 9, 1971]

§ 404.513 Liability of a certifying officer.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any individual.

(a) Where adjustment or recovery of such amount is waived under section 204(b) of the Act; or

(b) Where adjustment under section 204(a) of the Act is not completed prior to the death of all individuals against whose benefits or lump sums deductions are authorized; or

(c) Where a claim for recovery of an overpayment is compromised or collection or adjustment action is suspended or terminated pursuant to the Federal Claims Collection Act of 1966 (31 U.S.C. 951–953) (see § 404.515).

[34 FR 14889, Sept. 27, 1969]

§ 404.515 Collection and compromise of claims for overpayment.

(a) *General effect of the Federal Claims Collection Act of 1966.* Claims by the Administration against an individual for recovery of overpayments under title II or title XVIII (not including title XVIII overpayments for which refund is requested from providers, physicians, or other suppliers of services) of the Act, not exceeding the sum of $20,000, exclusive of interest, may be compromised, or collection suspended or terminated where such individual or his estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section) or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section) except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension or termination of collection of a claim for overpayment*—(1) *Overpaid individual alive.* In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having an interest in the claim.

(2) *Overpaid individual deceased.* In any case where the overpaid individual is deceased (i) a claim for overpayment in excess of $5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud; the filing of a false claim, or misrepresentation on the part of such deceased individual, and (ii) a claim for overpayment regardless of the amount will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under title II or title XVIII of the Act, the Administration will consider such individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Administration will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the

Administration will consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under title II or title XVIII of the Act would not justify enforced collection proceedings for the full amount of the claim or there is doubt concerning the Administration's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount will be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under title II or title XVIII of the Act shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings giving due consideration to the exemptions available to the overpaid individual under State or Federal law and the time which such collection will take.

(f) *Payment.* Payment of the amount which the Administration has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under title II or title XVIII of the Act must be made within the time and in the manner set by the Administration. A claim for such recovery of the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Administration. Failure of the overpaid individual or his estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

[34 FR 14889, Sept. 27, 1969; 34 FR 15413, Oct. 3, 1969]

§ 404.520 Referral of overpayments to the Department of the Treasury for tax refund offset—General.

(a) The standards we will apply and the procedures we will follow before requesting the Department of the Treasury to offset income tax refunds due taxpayers who have an outstanding overpayment are set forth in §§ 404.520 through 404.526. These standards and procedures are authorized by 31 U.S.C. 3720A and are implemented through Department of the Treasury regulations at 31 CFR 285.2.

(b) We will use the Department of the Treasury tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable, and eligible for tax refund offset under regulations issued by the Department of the Treasury. We will use these procedures to collect overpayments only from individuals who are not currently entitled to monthly Social Security benefits under title II of the Act. We will refer an overpayment to the Department of the Treasury for offset against tax refunds no later than 10 years after our right to collect the overpayment first accrued.

[62 FR 64277, Dec. 5, 1997]

§ 404.521 Notice to overpaid individual.

A request for reduction of a Federal income tax refund will be made only after we determine that an amount is owed and past due and send the overpaid individual written notice. Our notice of intent to collect an overpayment through tax refund offset will state:

(a) The amount of the overpayment;

(b) That unless, within 60 calendar days from the date of our notice, the overpaid individual repays the overpayment, sends evidence to us at the address given in our notice that the overpayment is not past due or not legally enforceable, or asks us to waive collection of the overpayment under section 204(b) of the Act, we intend to seek collection of the overpayment by requesting that the Department of the Treasury reduce any amounts payable to the overpaid individual as refunds of Federal income taxes by an amount equal to the amount of the overpayment;

(c) The conditions under which we will waive recovery of an overpayment under section 204(b) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That the overpaid individual has the right to inspect and copy our records related to the overpayment as determined by us and will be informed

as to where and when the inspection and copying can be done after we receive notice from the overpaid individual that inspection and copying are requested.

[56 FR 52468, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.522 Review within SSA that an overpayment is past due and legally enforceable.

(a) *Notification by overpaid individual.* An overpaid individual who receives a notice as described in § 404.521 has the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, the individual must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* The overpaid individual may submit evidence showing that all or part of the debt is not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days will result in referral of the overpayment to the Department of the Treasury, unless the overpaid individual, within this 60-day time period, has asked us to waive collection of the overpayment under section 204(b) of the Act and we have not yet determined whether we can grant the waiver request. If the overpaid individual asks us to waive collection of the overpayment, we may ask that evidence to support the request be submitted to us.

(c) *Review of the evidence.* After a timely submission of evidence by the overpaid individual, we will consider all available evidence related to the overpayment. If the overpaid individual has not requested a waiver we will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence. If the overpaid individual has asked us to make a waiver determination and our records do not show that after an oral hearing we had previously determined that he was at ''fault'' in accepting the overpayment, we will not deny the waiver request without first scheduling an oral hearing.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.523 Findings by SSA.

(a) Following the hearing or a review of the record, we will issue written findings which include supporting rationale for the findings. Issuance of these findings concerning whether the overpayment or part of the overpayment is past due and legally enforceable is the final Agency action with respect to the past-due status and enforceability of the overpayment. If we make a determination that a waiver request cannot be granted, we will issue a written notice of this determination in accordance with the regulations in subpart J of this part. Our referral of the overpayment to the Department of the Treasury will not be suspended under § 404.525 pending any further administrative review of the waiver request that the individual may seek.

(b) Copies of the findings described in paragraph (a) of this section will be distributed to the overpaid individual and the overpaid individual's attorney or other representative, if any.

(c) If the findings referred to in paragraph (a) of this section affirm that all or part of the overpayment is past due and legally enforceable and, if waiver is requested, we determine that the request cannot be granted, we will refer the overpayment to the Department of the Treasury. No referral will be made to the Department of the Treasury if, based on our review of the overpayment, we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of our collection of the overpayment is appropriate.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.524 Review of our records related to the overpayment.

(a) *Notification by the overpaid individual.* An overpaid individual who intends to inspect or copy our records related to the overpayment as determined by us must notify us stating his or her intention to inspect or copy.

(b) *Our response.* In response to a notification by the overpaid individual as described in paragraph (a) of this section, we will notify the overpaid individual of the location and time when the overpaid individual may inspect or copy our records related to the overpayment. We may also, at our discretion, mail copies of the overpayment-related records to the overpaid individual.

[56 FR 52469, Oct. 21, 1991]

§ 404.525 Suspension of offset.

If, within 60 days of the date of the notice described in § 404.521, the overpaid individual notifies us that he or she is exercising a right described in § 404.522(a) and submits evidence pursuant to § 404.522(b) or requests a waiver under § 404.506, we will suspend any notice to the Department of the Treasury until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

[56 FR 52469, Oct. 21, 1991, as amended at 62 FR 64278, Dec. 5, 1997]

§ 404.526 Tax refund insufficient to cover amount of overpayment.

If a tax refund for a given taxable year is insufficient to recover an overpayment completely, the case will remain with the Department of the Treasury for offset, assuming that all criteria for offset continue to be met.

[62 FR 64278, Dec. 5, 1997]

§ 404.527 Additional methods for recovery of title II benefit overpayments.

(a) *General.* In addition to the methods specified in §§ 404.502 and 404.520, an overpayment under title II of the Act is also subject to recovery under the rules in subpart D of part 422, provided:

(1) The overpayment occurred after the individual has attained age 18;

(2) The overpaid individual is no longer entitled to benefits under title II of the Act; and

(3) Pursuant to paragraph (b) of this section, we have determined that the overpayment is otherwise unrecoverable under section 204 of the Act.

(b) *When an overpayment is considered to be otherwise unrecoverable.* An overpayment under title II of the Act is considered to be otherwise unrecoverable under section 204 of the Act if all of the following conditions are met:

(1) Our billing system sequence has been completed (i.e., we have sent the individual an initial notice of the overpayment, a reminder notice, and a past-due notice) or collection activity has been suspended or terminated in accordance with the Federal Claims Collection Standards in 4 CFR 104.2 or 104.3.

(2) We have not entered into an installment payment arrangement with the overpaid individual or, if we have entered into such an arrangement, the overpaid individual has failed to make any payment for two consecutive months.

(3) The overpaid individual has not requested waiver pursuant to § 404.506 or § 404.522 or, after a review conducted pursuant to those sections, we have determined that we will not waive collection of the overpayment.

(4) The overpaid individual has not requested reconsideration of the initial overpayment determination pursuant to §§ 404.907 and 404.909 or, after a review conducted pursuant to § 404.913, we have affirmed, in whole or in part, the initial overpayment determination.

(5) The overpayment cannot be recovered pursuant to § 404.502 by adjustment of benefits payable to any individual other than the overpaid individual. For purposes of this paragraph, an overpayment will be deemed to be unrecoverable from any individual who was living in a separate household from the overpaid person at the time of the overpayment and did not receive the overpayment.

[62 FR 64278, Dec. 5, 1997]

Subpart G—Filing of Applications and Other Forms

AUTHORITY: Secs. 202 (i), (j), (o), (p), and (r), 205(a), 216(i)(2), 223(b), 228(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 402 (i), (j), (o), (p), and (r), 405(a), 416(i)(2), 423(b), 428(a), and 902(a)(5)).

SOURCE: 44 FR 37209, June 26, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.601 Introduction.

This subpart contains the Social Security Administration's rules for filing a claim for old-age, disability, dependents', and survivors' insurance benefits as described in subpart D of part 404. It tells what an application is, who may sign it, where and when it must be signed and filed, the period of time it is in effect and how it may be withdrawn. This subpart also explains when a written statement, request, or notice will be considered filed. Since the application form and procedures for filing a claim under this subpart are the same as those used to establish entitlement to Medicare benefits under 42 CFR part 405, persons who wish to become entitled to Medicare benefits should refer to the provisions of this subpart. Requirements concerning applications for the black lung benefits program are contained in part 410. Requirements concerning applications for the supplemental security income program are contained in part 416. Part 422 contains the requirements for applying for a social security number.

§ 404.602 Definitions.

For the purpose of this subpart—

Applicant means the person who files an application for benefits for himself or herself or for someone else. A person who files for himself or herself is both the *applicant* and the *claimant*.

Application refers only to an application on a form described in § 404.611.

Benefits means any old-age, disability, dependents', and survivors' insurance benefits described in subpart D, including a period of disability.

Claimant means the person who files an application for benefits for himself or herself or the person for whom an application is filed.

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

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

§ 404.603 You must file an application to receive benefits.

In addition to meeting other requirements, you must file an application to become entitled to benefits. If you believe you may be entitled to benefits, you should file an application. Filing an application will—

(a) Permit a formal decision to be made on your entitlement to benefits;

(b) Protect your entitlement to any benefits that may be payable for as many as 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the application was filed; and

(c) Give you the right to appeal if you are dissatisfied with the decision.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47444, Sept. 28, 1981]

APPLICATIONS

§ 404.610 What makes an application a claim for benefits.

To be considered a claim for benefits, an application must generally meet all of the following conditions:

(a) It must be on an application form as described in § 404.611.

(b) It must be completed and filed with SSA as described in § 404.611.

(c) It must be signed by the claimant or someone described in § 404.612. who may sign an application for the claimant.

(d) The claimant, with the limited exceptions in § 404.615, must be alive at the time it is filed.

§ 404.611 Filing of application with Social Security Administration.

(a) *General rule.* You must apply for benefits on an applications we prescribe. See § 404.614 for places where an application for benefits may be filed.

(b) *Effect of claims filed with the Railroad Retirement Board.* Pursuant to section 5(b) of the Railroad Retirement Act of 1974, as amended, 45 U.S.C. 231d(b), if you file an application with the Railroad Retirement Board on one of its forms for an annuity under section 2 of the Railroad Retirement Act of 1974, as amended, 45 U.S.C. 231a, unless you specify otherwise, this application also will be an application for any benefit to which you may be entitled

under title II of the Social Security Act.

(c) *Effect of claims filed with the Veterans Administration.* An application filed with the Veterans Administration on one of its forms for survivors' dependency and indemnity compensation (see section 3005 of title 38 U.S.C.) is also considered an application for social security dependents' and survivors' benefits except the lump-sum death payment.

[44 FR 37209, June 26, 1979, as amended at 51 FR 41951, Nov. 20, 1986; 58 FR 60381, Nov. 16, 1993]

§ 404.612 Who may sign an application.

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

(a) A claimant who is 18 years old or over, mentally competent, and physically able to do so, must sign his or her own application. If the claim is for child's benefits for a person who is not yet 22 years old, the application may be signed by a parent or a person standing in place of the parent.

(b) A claimant who is between 16 and 18 years old may sign his or her own application if he or she is mentally competent, has no court appointed representative, and is not in the care of any person.

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

(d) If a person who could receive disability benefits or who could have a period of disability established dies before filing, an application for disability benefits or for a period of disability may be signed by a person who would be qualified to receive any benefits due the deceased.

(e) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(f) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633 (b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633 (b)(1)(ii) and (b)(2)(ii).

(g) If it is necessary to protect a claimant from losing benefits and there is good cause for the claimant not signing the application, we may accept an application signed by some one other than a person described in this section.

Example: Mr. Smith comes to a social security office a few days before the end of a month to file an application for old-age benefits for his neighbor, Mr. Jones. Mr. Jones, a 63 year old widower, just suffered a heart attack and is in the hospital. He asked Mr. Smith to file the application for him. We will accept an application signed by Mr. Smith since it would not be possible to have Mr. Jones sign and file the application until the next calendar month and a loss of one month's benefits would result.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994; 61 FR 41330, Aug. 8, 1996]

§ 404.613 Evidence of authority to sign an application for another.

(a) A person who signs an application for someone else will be required to provide evidence of his or her authority to sign the application for the person claiming benefits under the following rules:

(1) If the person who signs is a court appointed representative, he or she must submit a certificate issued by the court showing authority to act for the claimant.

(2) If the person who signs is not a court appointed representative, he or she must submit a statement describing his or her relationship to the claimant. The statement must also describe the extent to which the person is responsible for the care of the claimant. This latter information will not be requested if the application is signed by a parent for a child with whom he or she is living.

(3) If the person who signs is the manager or principal officer of an institution which is responsible for the

care of the claimant, he or she must submit a statement indicating the person's position of responsibility at the institution.

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

§ 404.614 When an application or other form is considered filed.

(a) *General rule.* Except as otherwise provided in paragraph (b) of this section and in §§ 404.630 through 404.633 which relate to the filing date of an application, an application for benefits, or a written statement, request, or notice is filed on the day it is received by an SSA employee at one of our offices or by an SSA employee who is authorized to receive it at a place other than one of our offices.

(b) *Other places and dates of filing.* We will also accept as the date of filing—

(1) The date an application for benefits, or a written statement, request or notice is received by any office of the U.S. Foreign Service or by the Veterans Administration Regional Office in the Philippines;

(2) The date an application for benefits or a written statement, request or notice is mailed to us by the U.S. mail, if using the date we receive it would result in the loss or lessening of rights. The date shown by a U.S. postmark will be used as the date of mailing. If the postmark is unreadable, or there is no postmark, we will consider other evidence of when you mailed it to us; or

(3) The date an application for benefits is filed with the Railroad Retirement Board or the Veterans Administration. See § 404.611 (b) and (c) for an explanation of when an application for benefits filed with the Railroad Retirement Board or the Veterans Administration is considered an application for social security benefits.

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994]

§ 404.615 Claimant must be alive when an application is filed.

A claimant must be alive at the time an application is filed. There are the following exceptions to this general rule:

(a) If a disabled person dies before filing an application for disability benefits or a period of disability, a person who would be qualified to receive any benefits due the deceased may file an application. The application must be filed within 3 months after the month in which the disabled person died.

(b) If a written statement showing an intent to claim benefits is filed with us, but the person for whom the benefits are claimed dies before an application is filed, an application may be filed as explained in § 404.630(d).

(c) If a person who could receive benefits on the basis of a ''deemed'' filing date of an application under § 404.633 (b)(1)(i) or (b)(2)(i) dies before an application for the benefits is filed, the application may be signed by a person who would be qualified to receive any benefits due the deceased person as explained in § 404.633 (b)(1)(ii) and (b)(2)(ii).

[44 FR 37209, June 26, 1979, as amended at 59 FR 44923, Aug. 31, 1994; 61 FR 41330, Aug. 8, 1996]

EFFECTIVE FILING PERIOD OF APPLICATION

§ 404.620 Filing before the first month you meet the requirements for benefits.

(a) *General rule.* If you file an application for benefits (except special age 72 payments) before the first month you meet all the other requirements for entitlement, the application will remain in effect until we make a final determination on your application unless there is an administrative law judge hearing decision on your application. If there is an administrative law judge hearing decision, your application will remain in effect until the administrative law judge hearing decision is issued.

(1) If you meet all the requirements for entitlement while your application is in effect, we may pay you benefits from the first month that you meet all the requirements.

(2) If you first meet all the requirements for entitlement after the period for which your application was in effect, you must file a new application for benefits. In this case, we may pay you benefits only from the first month

that you meet all the requirements based on the new application.

(b) *Filing for special age 72 payments.* The requirements for entitlement to special age 72 payments must be met no later than 3 months after the month an application is filed.

[44 FR 37209, June 26, 1979, as amended at 52 FR 4003, Feb. 9, 1987]

§ 404.621 Filing after the first month you meet the requirements for benefits.

(a) *Filing for disability benefits and for old-age, survivors', or dependents' benefits.* (1)(i) If you file an application for disability benefits, widow's or widower's benefits based on disability, or wife's, husband's, or child's benefits based on the earnings record of a person entitled to disability benefits, after the first month you could have been entitled to them, you may receive benefits for up to 12 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 12-month period in which you meet all the requirements for entitlement. However, entitlement to wife's or husband's benefits under this rule is limited by paragraph (a)(1)(iii) of this section.

(ii) If you file an application for old-age benefits, widow's or widower's benefits not based on disability, wife's, husband's, or child's benefits based on the earnings record of a person not entitled to disability benefits, or mother's, father's, or parent's benefits, after the first month you could have been entitled to them, you may receive benefits for up to 6 months immediately before the month in which your application is filed. Your benefits may begin with the first month in this 6-month period in which you meet all the requirements for entitlement. However, entitlement to old-age, wife's, husband's, widow's, or widower's benefits under this rule is limited by paragraph (a)(1)(iii) of this section.

(iii) If the effect of the payment of benefits for a month before the month you file would be to reduce your benefits because of your age, you cannot be entitled to old-age, wife's, husband's, widow's, or widower's benefits for any month before the month in which your application is filed, unless you meet one of the conditions in paragraph (a)(2) of this section. (An explanation of the reduction that occurs because of age if you are entitled to these benefits for a month before you reach the retirement age of 65, is in § 404.410.) An example follows that assumes you do not meet any of the conditions in paragraph (a)(2) of this section.

Example: You become 65 years old in April 1981. If you apply for old-age benefits in April, you cannot be entitled to benefits for months in the 6-month period before April because the payment of benefits for any of these months would result in your benefits being reduced for age. If you do not file your application until July 1981, you may be entitled to benefits for the months of April, May, and June 1981 because the payment of benefits for these months would not result in your benefits being reduced for age. You will not, however, receive benefits for the 3 months before April.

(2) The limitation in paragraph (a)(1)(iii) of this section on your entitlement to old-age, wife's, husband's, widow's, or widower's benefits for months before you file an application does not apply if—

(i) You are a widow, widower, surviving divorced wife, or surviving divorced husband who is disabled and could be entitled to retroactive benefits for any month before age 60. If you could not be entitled before age 60, the limitation will prevent payment of benefits to you for past months, but it will not affect the month you become entitled to hospital insurance benefits.

(ii) You are a widow, widower, or surviving divorced spouse of the insured person who died in the month before you applied and you were at least age 60 in the month of death of the insured person on whose earnings record you are claiming benefits. In this case, you can be entitled beginning with the month the insured person died if you choose and if you file your application on or after July 1, 1983.

(b) *Filing for lump-sum death payment.* An application for a lump-sum death payment must be filed within 2 years after the death of the person on whose earnings record the claim is filed. There are two exceptions to the 2-year filing requirement:

(1) If there is a good cause for failure to file within the 2-year period, we will consider your application as though it

were filed within the 2-year period. Good cause does not exist if you were informed of the need to file an application within the 2-year period and you neglected to do so or did not desire to make a claim. Good cause will be found to exist if you did not file within the time limit due to—

(i) Circumstances beyond your control, such as extended illness, mental or physical incapacity, or a language barrier;

(ii) Incorrect or incomplete information we furnished you;

(iii) Your efforts to get evidence to support your claim without realizing that you could submit the evidence after filing an application; or

(iv) Unusual or unavoidable circumstances which show that you could not reasonably be expected to know of the time limit.

(2) The Soldiers' and Sailors' Civil Relief Act of 1940 provides for extending the filing time.

(c) *Filing for special age 72 payments.* An application for special age 72 payments is not effective as a claim for benefits for any month before you actually file.

(d) *Filing for a period of disability.* You must file an application for a period of disability while you are disabled or no later than 12 months after the month in which your period of disability ended. If you were unable to apply within the 12-month time period because of a physical or mental condition, you may apply not more than 36 months after your disability ended. The general rule we use to decide whether your failure to file was due to a physical or mental condition is stated in subpart D.

(e) *Filing after death of person eligible for disability benefits or period of disability.* If you file for disability benefits or a period of disability for another person who died before filing an application and you would qualify under § 404.503(b) to receive any benefits due the deceased, you must file an application no later than the end of the third month following the month in which the disabled person died.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47444, Sept. 28, 1981; 51 FR 4482, Feb. 5, 1986; 56 FR 58846, Nov. 22, 1991]

§ 404.622 Limiting an application.

Your application may entitle you to benefits for up to 6 months or 12 months (depending on the type of benefit, as explained in § 404.621) before the month in which it is filed. You may limit the number of months of your entitlement in the 6-month or 12-month period. You may state this choice any time before a decision is made on your claim by indicating, in writing, the month you want your benefits to begin. You may change the first month of entitlement in this 6-month or 12-month period after a decision has been made on your claim under the following conditions:

(a) You file the request in writing.

(b) If you are filing for the claimant, he or she is alive when the request is filed.

(c) If any other person who is entitled to benefits would lose some or all of those benefits because of the change, that person, or the person who filed for him or her, consents in writing.

(d) Any benefit payments that would become improper as a result of the change in entitlement month are repaid, or we are satisfied that they will be repaid.

[44 FR 37209, June 26, 1979, as amended at 46 FR 47445, Sept. 28, 1981]

§ 404.623 Filing by person eligible for old-age and husband's or wife's benefits.

(a) *Presumed filing for husband's or wife's benefits.* If you file an application for old-age benefits, you are presumed to have filed an application for husband's or wife's benefits in the first month of your entitlement to old-age benefits, if—

(1) Your old-age benefits are reduced for age because you choose to receive them before you become 65 years old; and

(2) You are eligible for either a husband's or a wife's benefit for the first month of your entitlement to old-age benefits.

(b) *Presumed filing for old-age benefits.* (1) If you file an application for a husband's or a wife's benefits, you are presumed to have filed an application for old-age benefits in the first month of your entitlement to husband's or wife's benefits if—

(i) Your husband's or wife's benefits are reduced for age because you choose to receive them before you become 65 years old; and

(ii) You are eligible for old-age benefits for the first month of your entitlement to husband's or wife's benefits.

(2) The rule in paragraph (b)(1) of this section is not used if you are also entitled to disability benefits in the first month of your entitlement to husband's or wife's benefits. In this event, you are presumed to have filed for old-age benefits only if your disability benefits end before you become 65 years old.

FILING DATE BASED ON WRITTEN STATEMENT

§ 404.630 Use of date of written statement as filing date.

If a written statement, such as a letter, indicating your intent to claim benefits either for yourself or for another person is filed with us under the rules stated in § 404.614, we will use the filing date of the written statement as the filing date of the application, if all of the following requirements are met:

(a) The statement indicates an intent to claim benefits.

(b) The statement is signed by the claimant, the claimant's spouse, or a person described in § 404.612. If you telephone us and advise us that you intend to file a claim but cannot file an application before the end of the month, we will prepare and sign a written statement if it is necessary to prevent the loss of benefits.

(c) The claimant files an application with us on an application form as described in § 404.611, or one is filed for the claimant by a person described in § 404.612, within 6 months after the date of a notice we will send advising of the need to file an application. We will send the notice to the claimant. However, if it is clear from the information we receive that the claimant is a minor or is mentally incompetent, we will send the notice to the person who submitted the written statement.

(d) The claimant is alive when the application is filed; or if the claimant has died after the written statement was filed, an application is filed—

(1) By or for a person who would be eligible to receive benefits on the deceased's earnings record;

(2) By a person acting for the deceased's estate; or

(3) If the statement was filed with a hospital under § 404.632, by the hospital if—

(i) No person described in paragraph (d) (1) or (2) of this section can be located; or

(ii) A person described in paragraphs (d) (1) or (2) of this section is located but refuses or fails to file the application unless the refusal or failure to file is because it would be harmful to the deceased person or the deceased's estate.

§ 404.631 Statements filed with the Railroad Retirement Board.

A written statement filed with the Railroad Retirement Board will be considered a written statement filed with us under the rules in § 404.630 if—

(a) The statement indicates an intent to claim any payments under the Railroad Retirement Act;

(b) It bears the signature of the person filing the statement;

(c) No application is filed with the Railroad Retirement Board on one of its forms. If an application has been filed, we will use the date of filing of that application as determined by the Railroad Retirement Board (see § 404.614(b)(3)); and

(d) The statement is sent to us by the Railroad Retirement Board.

§ 404.632 Statements filed with a hospital.

A statement (generally a hospital admission form) filed with a hospital may serve as a written statement under § 404.630 if the requirements of this section are met. The statement will be considered filed with us as of the date it was filed with the hospital and will serve to protect entitlement to benefits. A statement filed with a hospital by you or some other person for you requesting or indicating an intent to claim benefits will be considered a written statement filed with us and § 404.630 will apply to it if—

(a) You are a patient in the hospital;

(b) The hospital provides services covered by hospital insurance under the Medicare program;

(c) An application has not already been filed; and

(d) The statement is sent to us.

DEEMED FILING DATE BASED ON MISINFORMATION

§ 404.633 Deemed filing date in a case of misinformation.

(a) *General.* You may have considered applying for monthly benefits for yourself or for another person, and you may have contacted us in writing, by telephone or in person to inquire about filing an application for these benefits. It is possible that in responding to your inquiry, we may have given you misinformation about your eligibility for such benefits, or the eligibility of the person on whose behalf you were considering applying for benefits, which caused you not to file an application at that time. If this happened, and later an application for such benefits is filed with us, we may establish an earlier filing date under this section.

Example 1: Mrs. Smith, a widow of an insured individual, contacts a Social Security office when she reaches age 60 to inquire about applying for widow's insurance benefits. She is told by an SSA employee that she must be age 62 to be eligible for these benefits. This information, which was incorrect, causes Mrs. Smith not to file an application for benefits. When Mrs. Smith reaches age 62, she again contacts a Social Security office to ask about filing for widow's insurance benefits and learns that she could have received the benefits at age 60. She files an application for these benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation which she received from an SSA employee when she was age 60.

Example 2: Ms. Hill, a 22-year-old, is forced to stop work because of illness. When she contacts a Social Security office to inquire about applying for disability insurance benefits, she is told by an SSA employee that she must have 20 quarters of coverage out of the last 40 calendar quarters to be insured for disability insurance benefits. The employee fails to consider the special rules for insured status for persons who become disabled before age 31 and, consequently, tells Ms. Hill that she is not insured because she only has 16 quarters of coverage. The misinformation causes Ms. Hill not to file an application for disability insurance benefits. Because of her illness, she is unable to return to work. A year later, Ms. Hill reads an article that indicates that there are special rules for insured status for young workers who become disabled. She again contacts a Social Security office to inquire about benefits based on disability and learns that she was misinformed earlier about her insured status. She files an application for disability insurance benefits, provides the information required under paragraph (f) of this section to show that an SSA employee provided misinformation, and requests a deemed filing date based on the misinformation provided to her earlier.

(b) *Deemed filing date of an application based on misinformation.* Subject to the requirements and conditions in paragraphs (c) through (g) of this section, we may establish a deemed filing date of an application for monthly benefits under the following provisions.

(1)(i) If we determine that you failed to apply for monthly benefits for yourself because we gave you misinformation about your eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which you met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for you under paragraph (b)(1)(i) of this section, you or a person described in § 404.612 must file an application for such benefits. If you die before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due you.

(2)(i) If you had authority under § 404.612 to sign an application for benefits for another person, and we determine that you failed to apply for monthly benefits for that person because we gave you misinformation about that person's eligibility for such benefits, we will deem an application for such benefits to have been filed with us on the later of—

(A) The date on which the misinformation was provided to you; or

(B) The date on which the person met all of the requirements for entitlement to such benefits, other than the requirement of filing an application.

(ii) Before we may establish a deemed filing date of an application for benefits for the person under paragraph (b)(2)(i) of this section, you, such person, or another person described in § 404.612 must file an application for such benefits. If the person referred to in paragraph (b)(2)(i) of this section dies before an application for the benefits is filed with us, we will consider establishing a deemed filing date of an application for such benefits only if an application for the benefits is filed with us by a person who would be qualified to receive any benefits due the deceased person.

(c) *Requirements concerning the misinformation.* We apply the following requirements for purposes of paragraph (b) of this section.

(1) The misinformation must have been provided to you by one of our employees while he or she was acting in his or her official capacity as our employee. For purposes of this section, an employee includes an officer of SSA.

(2) Misinformation is information which we consider to be incorrect, misleading, or incomplete in view of the facts which you gave to the employee, or of which the employee was aware or should have been aware, regarding your particular circumstances, or the particular circumstances of the person referred to in paragraph (b)(2)(i) of this section. In addition, for us to find that the information you received was incomplete, the employee must have failed to provide you with the appropriate, additional information which he or she would be required to provide in carrying out his or her official duties.

(3) The misinformation may have been provided to you orally or in writing.

(4) The misinformation must have been provided to you in response to a specific request by you to us for information about your eligibility for benefits or the eligibility for benefits of the person referred to in paragraph (b)(2)(i) of this section for which you were considering filing an application.

(d) *Evidence that misinformation was provided.* We will consider the following evidence in making a determination under paragraph (b) of this section.

(1) *Preferred evidence.* Preferred evidence is written evidence which relates directly to your inquiry about your eligibility for benefits or the eligibility of another person and which shows that we gave you misinformation which caused you not to file an application. Preferred evidence includes, but is not limited to, the following—

(i) A notice, letter or other document which was issued by us and addressed to you; or

(ii) Our record of your telephone call, letter or in-person contact.

(2) *Other evidence.* In the absence of preferred evidence, we will consider other evidence, including your statements about the alleged misinformation, to determine whether we gave you misinformation which caused you not to file an application. We will not find that we gave you misinformation, however, based solely on your statements. Other evidence which you provide or which we obtain must support your statements. Evidence which we will consider includes, but is not limited to, the following—

(i) Your statements about the alleged misinformation, including statements about—

(A) The date and time of the alleged contact(s);

(B) How the contact was made, e.g., by telephone or in person;

(C) The reason(s) the contact was made;

(D) Who gave the misinformation; and

(E) The questions you asked and the facts you gave us, and the questions we asked and the information we gave you, at the time of the contact;

(ii) Statements from others who were present when you were given the alleged misinformation, e.g., a neighbor who accompanied you to our office;

(iii) If you can identify the employee or the employee can recall your inquiry about benefits—

(A) Statements from the employee concerning the alleged contact, including statements about the questions you asked, the facts you gave, the questions the employee asked, and the information provided to you at the time of the alleged contact; and

(B) Our assessment of the likelihood that the employee provided the alleged misinformation;

(iv) An evaluation of the credibility and the validity of your allegations in conjunction with other relevant information; and

(v) Any other information regarding your alleged contact.

(e) *Information which does not constitute satisfactory proof that misinformation was given.* Certain kinds of information will not be considered satisfactory proof that we gave you misinformation which caused you not to file an application. Examples of such information include—

(1) General informational pamphlets that we issue to provide basic program information;

(2) The Personal Earnings and Benefit Estimate Statement that is based on an individual's reported and projected earnings and is an estimate which can be requested at any time;

(3) General information which we review or prepare but which is disseminated by the media, e.g., radio, television, magazines, and newspapers; and

(4) Information provided by other governmental agencies, e.g., the Department of Veterans Affairs, the Department of Defense, State unemployment agencies, and State and local governments.

(f) *Claim for benefits based on misinformation.* You may make a claim for benefits based on misinformation at any time. Your claim must contain information that will enable us to determine if we did provide misinformation to you about your eligibility for benefits, or the eligibility of a person on whose behalf you were considering applying for benefits, which caused you not to file an application for the benefits. Specifically, your claim must be in writing and it must explain what information was provided; how, when and where it was provided and by whom; and why the information caused you not to file an application. If you give us this information, we will make a determination on such a claim for benefits if all of the following conditions are also met.

(1) An application for the benefits described in paragraph (b)(1)(i) or (b)(2)(i) of this section is filed with us by someone described in paragraph (b)(1)(ii) or (b)(2)(ii) of this section, as appropriate. The application must be filed after the alleged misinformation was provided. This application may be—

(i) An application on which we have made a previous final determination or decision awarding the benefits, but only if the claimant continues to be entitled to benefits based on that application;

(ii) An application on which we have made a previous final determination or decision denying the benefits, but only if such determination or decision is reopened under § 404.988; or

(iii) A new application on which we have not made a final determination or decision.

(2) The establishment of a deemed filing date of an application for benefits based on misinformation could result in the claimant becoming entitled to benefits or to additional benefits.

(3) We have not made a previous final determination or decision to which you were a party on a claim for benefits based on alleged misinformation involving the same facts and issues. This provision does not apply, however, if the final determination or decision may be reopened under § 404.988.

(g) *Effective date.* This section applies only to misinformation which we provided after December 1982. In addition, this section is effective only for benefits payable for months after December 1982.

[59 FR 44924, Aug. 31, 1994]

WITHDRAWAL OF APPLICATION

§ 404.640 Withdrawal of an application.

(a) *Request for withdrawal filed before a determination is made.* An application may be withdrawn before we make a determination on it if—

(1) A written request for withdrawal is filed at a place described in § 404.614 by the claimant or a person who may sign an application for the claimant under § 404.612; and

(2) The claimant is alive at the time the request is filed.

(b) *Request for withdrawal filed after a determination is made.* An application may be withdrawn after we make a determination on it if—

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

(2) Any other person whose entitlement would be rendered erroneous because of the withdrawal consents in writing to it. Written consent for the person may be given by someone who could sign an application for him or her under § 404.612; and

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

(c) *Request for withdrawal filed after the claimant's death.* An application may be withdrawn after the claimant's death, regardless of whether we have made a determination on it, if—

(1) The claimant's application was for old-age benefits that would be reduced because of his or her age;

(2) The claimant died before we certified his or her benefit entitlement to the Treasury Department for payment;

(3) A written request for withdrawal is filed at a place described in § 404.614 by or for the person eligible for widow's or widower's benefits based on the claimant's earnings; and

(4) The conditions in paragraphs (b)(2) and (3) of this section are met.

(d) *Effect of withdrawal.* If we approve a request to withdraw an application, the application will be considered as though it was never filed. If we disapprove a request for withdrawal, the application is treated as though the request was never filed.

[44 FR 37209, June 26, 1979, as amended at 48 FR 21931, May 16, 1983; 51 FR 37720, Oct. 24, 1986]

§ 404.641 Cancellation of a request to withdraw.

A request to withdraw an application may be cancelled and the application reinstated if—

(a) A written request for cancellation is filed at a place described in § 404.614 by the claimant or someone who may sign an application for the claimant under § 404.612;

(b) The claimant is alive at the time the request for cancellation is filed; and

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

Subpart H—Evidence

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

SOURCE: 43 FR 24795, June 7, 1978, unless otherwise noted.

GENERAL

§ 404.701 Introduction.

This subpart contains the Social Security Administration's basic rules about what evidence is needed when a person claims old-age, disability, dependents' and survivors' insurance benefits as described in subpart D. In addition, there are special evidence requirements for disability benefits. These are contained in subpart P. Evidence of a person's earnings under social security is described in subpart I. Evidence needed to obtain a social security number card is described in part 422. Evidence requirements for the supplemental security income program are contained in part 416.

§ 404.702 Definitions.

As used in this subpart:

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

Benefits means any old-age, disability, dependents' and survivors' insurance benefits described in subpart D, including a period of disability.

Convincing evidence means one or more pieces of evidence that prove you meet a requirement for eligibility. See § 404.708 for the guides we use in deciding whether evidence is convincing.

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

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

Evidence means any record, document, or signed statement that helps to show whether you are eligible for benefits or whether you are still entitled to benefits.

Insured person means someone who has enough earnings under social security to permit the payment of benefits on his or her earnings record. He or she is *fully insured, transitionally insured, currently insured,* or *insured for disability* as defined in subpart B.

We or *Us* refers to the Social Security Administration.

You refers to the person who has applied for benefits, or the person for whom someone else has applied.

§ 404.703 When evidence is needed.

When you apply for benefits, we will ask for evidence that you are eligible for them. After you become entitled to benefits, we may ask for evidence showing whether you continue to be entitled to benefits; or evidence showing whether your benefit payments should be reduced or stopped. See § 404.401 for a list showing when benefit payments must be reduced or stopped.

§ 404.704 Your responsibility for giving evidence.

When evidence is needed to prove your eligibility or your right to continue to receive benefit payments, you will be responsible for obtaining and giving the evidence to us. We will be glad to advise you what is needed and how to get it and we will consider any evidence you give us. If your evidence is a foreign-language record or document, we can have it translated for you. Evidence given to us will be kept confidential and not disclosed to anyone but you except under the rules set out in part 401. You should also be aware that Section 208 of the Social Security Act provides criminal penalties for misrepresenting the facts or for making false statements to obtain social security benefits for yourself or someone else.

§ 404.705 Failure to give requested evidence.

Generally, you will be asked to give us by a certain date specific kinds of evidence or information to prove you are eligible for benefits. If we do not receive the evidence or information by that date, we may decide you are not eligible for benefits. If you are already receiving benefits, you may be asked to give us by a certain date information needed to decide whether you continue to be entitled to benefits or whether your benefits should be stopped or reduced. If you do not give us the requested information by the date given, we may decide that you are no longer entitled to benefits or that your benefits should be stopped or reduced. You should let us know if you are unable to give us the requested evidence within the specified time and explain why there will be a delay. If this delay is due to illness, failure to receive timely evidence you have asked for from another source, or a similar circumstance, you will be given additional time to give us the evidence.

§ 404.706 Where to give evidence.

Evidence should be given to the people at a Social Security Administration office. In the Philippines evidence should be given to the people at the Veterans Administration Regional Office. Elsewhere outside the United States, evidence should be given to the people at a United States Foreign Service Office.

§ 404.707 Original records or copies as evidence.

(a) *General.* To prove your eligibility or continuing entitlement to benefits, you may be asked to show us an original document or record. These original records or documents will be returned to you after we have photocopied them. We will also accept copies of original records that are properly certified and some uncertified birth notifications. These types of records are described below in this section.

(b) *Certified copies of original records.* You may give us copies of original records or extracts from records if they are certified as true and exact copies by—

(1) The official custodian of the record;

(2) A Social Security Administration employee authorized to certify copies;

(3) A Veterans Administration employee if the evidence was given to that agency to obtain veteran's benefits;

(4) A U.S. Consular Officer or employee of the Department of State authorized to certify evidence received outside the United States; or

(5) An employee of a State Agency or State Welfare Office authorized to certify copies of original records in the agency's or office's files.

(c) *Uncertified copies of original records.* You may give us an uncertified photocopy of a birth registration notification as evidence where it is the practice of the local birth registrar to issue them in this way.

§ 404.708 How we decide what is enough evidence.

When you give us evidence, we examine it to see if it is convincing evidence. If it is, no other evidence is needed. In deciding if evidence is convincing, we consider whether—

(a) Information contained in the evidence was given by a person in a position to know the facts;

(b) There was any reason to give false information when the evidence was created;

(c) Information contained in the evidence was given under oath, or with witnesses present, or with the knowledge there was a penalty for giving false information;

(d) The evidence was created at the time the event took place or shortly thereafter;

(e) The evidence has been altered or has any erasures on it; and

(f) Information contained in the evidence agrees with other available evidence, including our records.

§ 404.709 Preferred evidence and other evidence.

If you give us the type of evidence we have shown as *preferred* in the following sections of this subpart, we will generally find it is convincing evidence. This means that unless we have information in our records that raises a doubt about the evidence, other evidence of the same fact will not be needed. If preferred evidence is not available, we will consider any other evidence you give us. If this other evidence is several different records or documents which all show the same information, we may decide it is convincing evidence even though it is not *preferred* evidence. If the other evidence is not convincing by itself, we will ask for additional evidence. If this additional evidence shows the same information, all the evidence considered together may be convincing. When we have convincing evidence of the facts that must be proven or it is clear that the evidence provided does not prove the necessary facts, we will make a formal decision about your benefit rights.

EVIDENCE OF AGE, MARRIAGE, AND DEATH

§ 404.715 When evidence of age is needed.

(a) If you apply for benefits, we will ask for evidence of age which shows your date of birth unless you are applying for—

(1) A lump-sum death payment;

(2) A wife's benefit and you have the insured person's child in your care;

(3) A mother's or father's benefit; or

(4) A disability benefit (or for a period of disability) and neither your eligibility nor benefit amount depends upon your age.

(b) If you apply for wife's benefits while under age 62 or if you apply for a mother's or father's benefit, you will be asked for evidence of the date of birth of the insured person's children in your care.

(c) If you apply for benefits on the earnings record of a deceased person, you may be asked for evidence of his or her age if this is needed to decide whether he or she was insured at the time of death or what benefit amount is payable to you.

§ 404.716 Type of evidence of age to be given.

(a) *Preferred evidence.* The best evidence of your age, if you can obtain it, is either: a birth certificate or hospital birth record recorded before age 5; or a religious record which shows your date of birth and was recorded before age 5.

(b) *Other evidence of age.* If you cannot obtain the preferred evidence of your age, you will be asked for other convincing evidence that shows your date of birth or age at a certain time such as: an original family bible or family record; school records; census records; a statement signed by the physician or midwife who was present at

your birth; insurance policies; a marriage record; a passport; an employment record; a delayed birth certificate, your child's birth certificate; or an immigration or naturalization record.

§ 404.720 Evidence of a person's death.

(a) *When evidence of death is required.* If you apply for benefits on the record of a deceased person, we will ask for evidence of the date and place of his or her death. We may also ask for evidence of another person's death if this is needed to prove you are eligible for benefits.

(b) *Preferred evidence of death.* The best evidence of a person's death is—

(1) A certified copy or extract from the public record of death, coroner's report of death, or verdict of a coroner's jury; or a certificate by the custodian of the public record of death;

(2) A statement of the funeral director, attending physician, intern of the institution where death occurred;

(3) A certified copy of, or extract from an official report or finding of death made by an agency or department of the United States; or

(4) If death occurred outside the United States, an official report of death by a United States Consul or other employee of the State Department; or a copy of the public record of death in the foreign country.

(c) *Other evidence of death.* If you cannot obtain the preferred evidence of a person's death, you will be asked to explain why and to give us other convincing evidence such as: the signed statements of two or more people with personal knowledge of the death, giving the place, date, and cause of death.

§ 404.721 Evidence to presume a person is dead.

If you cannot prove the person is dead but evidence of death is needed, we will presume he or she died at a certain time if you give us the following evidence:

(a) A certified copy of, or extract from, an official report or finding by an agency or department of the United States that a missing person is *presumed to be* dead as set out in Federal law (5 U.S.C. 5565). Unless we have other evidence showing an actual date of death, we will use the date he or she was reported missing as the date of death.

(b) Signed statements by those in a position to know and other records which show that the person has been absent from his or her residence and has not been heard from for at least 7 years. If the presumption of death is not rebutted pursuant to § 404.722, we will use as the person's date of death either the date he or she left home, the date ending the 7 year period, or some other date depending upon what the evidence shows is the most likely date of death.

(c) If you are applying for benefits as the insured person's grandchild or stepgrandchild but the evidence does not identify a parent, we will presume the parent died in the first month in which the insured person became entitled to to benefits.

[43 FR 24795, June 7, 1978, as amended at 60 FR 19164, Apr. 17, 1995]

§ 404.722 Rebuttal of a presumption of death.

A presumption of death made based on § 404.721(b) can be rebutted by evidence that establishes that the person is still alive or explains the individual's absence in a manner consistent with continued life rather than death.

Example 1: Evidence in a claim for surviving child's benefits showed that the worker had wages posted to his earnings record in the year following the disappearance. It was established that the wages belonged to the worker and were for work done after his ''disappearance.'' In this situation, the presumption of death is rebutted by evidence (wages belonging to the worker) that the person is still alive after the disappearance.

Example 2: Evidence shows that the worker left the family home shortly after a woman, whom he had been seeing, also disappeared, and that the worker phoned his wife several days after the disappearance to state he intended to begin a new life in California. In this situation the presumption of death is rebutted because the evidence explains the worker's absence in a manner consistent with continued life.

[60 FR 19165, Apr. 17, 1995]

§ 404.723 When evidence of marriage is required.

If you apply for benefits as the insured person's husband or wife, widow

or widower, divorced wife or divorced husband, we will ask for evidence of the marriage and where and when it took place. We may also ask for this evidence if you apply for child's benefits or for the lump-sum death payment as the widow or widower. If you are a widow, widower, or divorced wife who remarried after your marriage to the insured person ended, we may also ask for evidence of the remarriage. You may be asked for evidence of someone else's marriage if this is necessary to prove your marriage to the insured person was valid. In deciding whether the marriage to the insured person is valid or not, we will follow the law of the State where the insured person had his or her permanent home when you applied or, if earlier, when he or she died—see § 404.770. What evidence we will ask for depends upon whether the insured person's marriage was a ceremonial marriage, a common-law marriage, or a marriage we will deem to be valid.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

§ 404.725 Evidence of a valid ceremonial marriage.

(a) *General.* A valid *ceremonial marriage* is one that follows procedures set by law in the State or foreign country where it takes place. These procedures cover who may perform the marriage ceremony, what licenses or witnesses are needed, and similar rules. A ceremonial marriage can be one that follows certain tribal Indian custom, Chinese custom, or similar traditional procedures. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a ceremonial marriage is—

(1) If you are applying for wife's or husband's benefits, signed statements from you and the insured about when and where the marriage took place. If you are applying for the lump-sum death payment as the widow or widower, your signed statement about when and where the marriage took place; or

(2) If you are applying for any other benefits or there is evidence causing some doubt about whether there was a ceremonial marriage: a copy of the public record of marriage or a certified statement as to the marriage; a copy of the religious record of marriage or a certified statement as to what the record shows; or the original marriage certificate.

(c) *Other evidence of a ceremonial marriage.* If preferred evidence of a ceremonial marriage cannot be obtained, we will ask you to explain why and to give us a signed statement of the clergyman or official who held the marriage ceremony, or other convincing evidence of the marriage.

§ 404.726 Evidence of common-law marriage.

(a) *General.* A *common-law marriage* is one considered valid under certain State laws even though there was no formal ceremony. It is a marriage between two persons free to marry, who consider themselves married, live together as man and wife, and, in some States, meet certain other requirements. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a common-law marriage is—

(1) If both the husband and wife are alive, their signed statements and those of two blood relatives;

(2) If either the husband or wife is dead, the signed statements of the one who is alive and those of two blood relatives of the deceased person; or

(3) If both the husband and wife are dead, the signed statements of one blood relative of each;

NOTE: All signed statements should show why the signer believes there was a marriage between the two persons. If a written statement cannot be gotten from a blood relative, one from another person can be used instead.

(c) *Other evidence of common-law marriage.* If you cannot get preferred evidence of a common-law marriage, we will ask you to explain why and to give us other convincing evidence of the marriage. We may not ask you for statements from a blood relative or other person if we believe other evidence presented to us proves the common-law marriage.

§ 404.727 Evidence of a deemed valid marriage.

(a) *General.* A *deemed valid marriage* is a ceremonial marriage we consider

valid even though the correct procedures set by State law were not strictly followed or a former marriage had not yet ended. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence of a deemed valid marriage is—

(1) Evidence of the ceremonial marriage as described in § 404.725(b)(2);

(2) If the insured person is alive, his or her signed statement that the other party to the marriage went through the ceremony in good faith and his or her reasons for believing the marriage was valid or believing the other party thought it was valid;

(3) The other party's signed statement that he or she went through the marriage ceremony in good faith and his or her reasons for believing it was valid;

(4) If needed to remove a reasonable doubt, the signed statements of others who might have information about what the other party knew about any previous marriage or other facts showing whether he or she went through the marriage in good faith; and

(5) Evidence the parties to the marriage were living in the same household when you applied for benefits or, if earlier, when the insured person died (see § 404.760).

(c) *Other evidence of a deemed valid marriage.* If you cannot obtain preferred evidence of a deemed valid marriage, we will ask you to explain why and to give us other convincing evidence of the marriage.

§ 404.728 Evidence a marriage has ended.

(a) *When evidence is needed that a marriage has ended.* If you apply for benefits as the insured person's divorced wife or divorced husband, you will be asked for evidence of your divorce. If you are the insured person's widow or divorced wife who had remarried but that husband died, we will ask you for evidence of his death. We may ask for evidence that a previous marriage you or the insured person had was ended before you married each other if this is needed to show the latter marriage was valid. If you apply for benefits as an unmarried person and you had a marriage which was annulled, we will ask for evidence of the annulment. We will ask for the evidence described in this section.

(b) *Preferred evidence.* Preferred evidence a marriage has ended is—

(1) A certified copy of the decree of divorce or annulment; or

(2) Evidence the person you married has died (see § 404.720).

(c) *Other evidence a marriage has ended.* If you cannot obtain preferred evidence the marriage has ended, we will ask you to explain why and to give us other convincing evidence the marriage has ended.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

EVIDENCE FOR CHILD'S AND PARENT'S BENEFITS

§ 404.730 When evidence of a parent or child relationship is needed.

If you apply for parent's or child's benefits, we will ask for evidence showing your relationship to the insured person. What evidence we will ask for depends on whether you are the insured person's natural parent or child; or whether you are the stepparent, stepchild, grandchild, stepgrandchild, adopting parent or adopted child.

§ 404.731 Evidence you are a natural parent or child.

If you are the natural parent of the insured person, we will ask for a copy of his or her public or religious birth record made before age 5. If you are the natural child of the insured person, we will ask for a copy of your public or religious birth record made before age 5. In either case, if this record shows the same last name for the insured and the parent or child, we will accept it as convincing evidence of the relationship. However, if other evidence raises some doubt about this record or if the record cannot be gotten, we will ask for other evidence of the relationship. We may also ask for evidence of marriage of the insured person or of his or her parent if this is needed to remove any reasonable doubt about the relationship. To show you are the child of the insured person, you may be asked for evidence you would be able to inherit his or her personal property under State law where he or she had a

permanent home (see § 404.770). In addition, we may ask for the insured persons signed statement that you are his or her natural child, or for a copy of any court order showing the insured has been declared to be your natural parent or any court order requiring the insured to contribute to you support because you are his or her son or daughter.

§ 404.732 Evidence you are a stepparent or stepchild.

If you are the stepparent or stepchild of the insured person, we will ask for the evidence described in § 404.731 or § 404.733 that which shows your natural or adoptive relationship to the insured person's husband, wife, widow, or widower. We will also ask for evidence of the husband's, wife's, widow's, or widower's marriage to the insured person—see § 404.725.

§ 404.733 Evidence you are the legally adopting parent or legally adopted child.

If you are the adopting parent or adopted child, we will ask for the following evidence:

(a) A copy of the birth certificate made following the adoption; or if this cannot be gotten, other evidence of the adoption; and, if needed, evidence of the date of adoption;

(b) If the widow or widower adopted the child after the insured person died, the evidence described in paragraph (a) of this section; your written statement whether the insured person was living in the same household with the child when he or she died (see § 404.760); what support the child was getting from any other person or organization; and if the widow or widower had a deemed valid marriage with the insured person, evidence of that marriage—see § 404.727;

(c) If you are the insured's stepchild, grandchild, or stepgrandchild as well as his or her adopted child, we may also ask you for evidence to show how you were related to the insured before the adoption.

§ 404.734 Evidence you are an equitably adopted child.

In many States, the law will treat someone as a child of another if he or she agreed to adopt the child, the natural parents or the person caring for the child were parties to the agreement, he or she and the child then lived together as parent and child, and certain other requirements are met. If you are a child who had this kind or relationship to the insured person (or to the insured persons's wife, widow, or husband), we will ask for evidence of the agreement if it is in writing. If it is not in writing or cannot be gotten, other evidence may be accepted. Also, the following evidence will be asked for: Written statements of your natural parents and the adopting parents and other evidence of the child's relationship to the adopting parents.

§ 404.735 Evidence you are the grandchild or stepgrandchild.

If you are the grandchild or stepgrandchild of the insured person, we will ask you for the kind of evidence described in §§ 404.731 through 404.733 that shows your relationship to your parent and your parent's relationship to the insured.

§ 404.736 Evidence of a child's dependency.

(a) *When evidence of a child's dependency is needed.* If you apply for child's benefit's we may ask for evidence you were the insured person's dependent at a specific time—usually the time you applied or the time the insured died or became disabled. What evidence we ask for depends upon how you are related to the insured person.

(b) *Natural or adopted child.* If you are the insured person's natural or adopted child, we may ask for the following evidence:

(1) A signed statement by someone who knows the facts that confirms this relationship and which shows whether you were legally adopted by someone other than the insured. If you were adopted by someone else while the insured person was alive, but the adoption was annulled, we may ask for a certified copy of the annulment decree or other convincing evidence of the annulment.

(2) A signed statement by someone in a position to know showing when and where you lived with the insured and when and why you may have lived apart; and showing what contributions

the insured made to your support and when and how they were made.

(c) *Stepchild.* If you are the insured person's stepchild, we will ask for the following evidence:

(1) A signed statement by someone in a position to know—showing when and where you lived with the insured and when and why you may have lived apart.

(2) A signed statement by someone in a position to know showing you received at least one-half of your support from the insured for the one-year period ending at one of the times mentioned in paragraph (a) of this section; and the income end support you had in this period from any other source.

(d) *Grandchild or Stepgrandchild.* If you are the insured person's grandchild or stepgrandchild, we will ask for evidence described in paragraph (c) of this section showing that you were living together with the insured and receiving one-half of your support from him or her for the year before the insured became entitled to benefits or to a period of disability, or died. We will also ask for evidence of your parent's death or disability.

§ 404.745 Evidence of school attendance for child age 18 or older.

If you apply for child's benefits as a student age 18 or over, we may ask for evidence you are attending school. We may also ask for evidence from the school you attend showing your status at the school. We will ask for the following evidence:

(a) Your signed statement that you are attending school full-time and are not being paid by an employer to attend school.

(b) If you apply before the school year has started and the school is not a high school, a letter of acceptance from the school, receipted bill, or other evidence showing you have enrolled or been accepted at that school.

§ 404.750 Evidence of a parent's support.

If you apply for parent's benefits, we will ask you for evidence to show that you received at least one-half of your support from the insured person in the one-year period before he or she died or became disabled. We may also ask others who know the facts for a signed statement about your sources of support. We will ask you for the following evidence:

(a) The parent's signed statement showing his or her income, any other sources of support, and the amount from each source over the one-year period.

(b) If the statement described in paragraph (a) of this section cannot be obtained, other convincing evidence that the parent received one-half of his or her support from the insured person.

OTHER EVIDENCE REQUIREMENTS

§ 404.760 Evidence of living in the same household with insured person.

If you apply for the lump-sum death payment as the insured person's widow or widower, or for wife's, husband's, widow's, or widower's benefits based upon a deemed valid marriage as described in § 404.727, we will ask for evidence you and the insured were living together in the same household when he or she died; or if the insured is alive, when you applied for benefits. We will ask for the following as evidence of this:

(a) If the insured person is living, his or her signed statement and yours showing whether you were living together when you applied for benefits.

(b) If the insured person is dead, your signed statement showing whether you were living together when he or she died.

(c) If you and the insured person were temporarily living apart, a signed statement explaining where each was living, how long the separation lasted, and why you were separated. If needed to remove any reasonable doubts about this, we may ask for the signed statements of others in a position to know, or for other convincing evidence you and the insured were living together in the same household.

§ 404.762 Evidence of having a child in your care.

If you are under age 65 and apply for wife's benefits based upon caring for a child, or for mother's benefits as a widow or divorced wife, or for father's benefits as a widower, we will ask for

evidence that you have the insured person's child in your care. What evidence we will ask for depends upon whether the child is living with you or with someone else. You will be asked to give the following evidence:

(a) If the child is living with you, your signed statement showing that the child is living with you.

(b) If the child is living with someone else—

(1) Your signed statement showing with whom he or she is living and why he or she is living with someone else. We will also ask when he or she last lived with you and how long this separation will last, and what care and contributions you provide for the child;

(2) The signed statement of the one with whom the child is living showing what care you provide and the sources and amounts of support received for the child. If the child is in an institution, an official there should sign the statement. These statements are preferred evidence. If there is a court order or written agreement showing who has custody of the child, you may be asked to give us a copy; and

(3) If you cannot get the preferred evidence described in paragraph (b)(2) of this section, we will ask for other convincing evidence that the child is in your care.

§ 404.770 Evidence of where the insured person had a permanent home.

(a) *When evidence of the insured's permanent home is needed.* We may ask for evidence of where the insured person's permanent home was at the time you applied or, if earlier, the time he or she died if—

(1) You apply for benefits as the insured's wife, husband, widow, widower, parent or child; and

(2) Your relationship to the insured depends upon the State law that would be followed in the place where the insured had his or her permanent home when you applied for benefits or when he or she died.

(b) *What evidence is needed.* We will ask for the following evidence of the insured person's permanent home:

(1) Your signed statement showing where the insured considered his permanent home to be.

(2) If the statement in paragraph (b)(1) of this section or other evidence we have raises a reasonable doubt about where the insured's permanent home was, evidence of where he or she paid personal, property, or income taxes, or voted; or other convincing evidence of where his or her permanent home was.

§ 404.780 Evidence of "good cause" for exceeding time limits on accepting proof of support or application for a lump-sum death payment.

(a) *When evidence of good cause* is needed. We may ask for evidence that you had *good cause* (as defined in § 404.370(f)) for not giving us sooner proof of the support you received from the insured as his or her parent. We may also ask for evidence that you had *good cause* (as defined in § 404.621(b)) for not applying sooner for the lump-sum death payment. You may be asked for evidence of *good cause* for these delays if—

(1) You are the insured person's parent giving us proof of support more than 2 years after he or she died, or became disabled; or

(2) You are applying for the lump-sum death payment more than 2 years after the insured died.

(b) *What evidence of good cause* is needed. We will ask for the following evidence of good cause:

(1) Your signed statement explaining why you did not give us the proof of support or the application for lump-sum death payment within the specified 2 year period.

(2) If the statement in paragraph (b)(1) of the section or other evidence raises a reasonable doubt whether there was good cause, other convincing evidence of this.

[43 FR 24795, June 7, 1978, as amended at 44 FR 34493, June 15, 1979]

Subpart I—Records of Earnings

AUTHORITY: Secs. 205(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 702(a)(5), and 1143 of the Social Security Act (42 U.S.C. 405(a), (c)(1), (c)(2)(A), (c)(4), (c)(5), (c)(6), and (p), 902(a)(5), and 1320b–13).

SOURCE: 44 FR 38454, July 2, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.801 Introduction.

The Social Security Administration (SSA) keeps a record of the earnings of all persons who work in employment or self-employment covered under social security. We use these earnings records to determine entitlement to and the amount of benefits that may be payable based on a person's earnings under the retirement, survivors', disability and health insurance program. This subpart tells what is evidence of earnings, how you can find out what the record of your earnings shows, and how and under what circumstances the record of your earnings may be changed to correct errors.

§ 404.802 Definitions.

For the purpose of this subpart—

Earnings means wages and self-employment income earned by a person based on work covered by social security. (See subpart K for the rules about what constitutes wages and self-employment income for benefit purposes.)

Period means a taxable year when referring to self-employment income. When referring to wages it means a calendar quarter if the wages were reported or should have been reported quarterly by your employer or a calendar year if the wages were reported or should have been reported annually by your employer.

Record of earnings, earnings record, or *record* means SSA's records of the amounts of wages paid to you and the amounts of self-employment income you received, the periods in which the wages were paid and the self-employment income was received, and the quarters of coverage which you earned based on these earnings.

Survivor means your spouse, divorced wife, child, or parent, who survives you. *Survivor* also includes your surviving divorced wife who may be entitled to benefits as a surviving divorced mother.

Tax return means, as appropriate, a tax return of wages or a tax return of self-employment income (including information returns and other written statements filed with the Commissioner of Internal Revenue under chapter 2 or 21 of the Internal Revenue Code of 1954, as amended).

Time limit means a period of time 3 years, 3 months, and 15 days after any year in which you received earnings. The period may be extended by the Soldiers and Sailors Relief Act of 1940 because of your military service or the military service of certain relatives who survive you (50 U.S.C. App. 501 and following sections). Where the time limit ends on a Federal nonwork day, we will extend it to the next Federal work day.

Wage report means a statement filed by a State under section 218 of the Social Security Act or related regulations. This statement includes wage amounts for which a State is billed and wage amounts for which credits or refunds are made to a State according to an agreement under section 218 of the Act.

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

Year means a calendar year when referring to wages and a taxable year when referring to self-employment income.

You or *your* means any person for whom we maintain a record of earnings.

§ 404.803 Conclusiveness of the record of your earnings.

(a) *Generally.* For social security purposes, SSA records are evidence of the amounts of your earnings and the periods in which they were received.

(b) *Before time limit ends.* Before the time limit ends for a year, SSA records are evidence, but not conclusive evidence, of the amounts and periods of your earnings in that year.

(c) *After time limit ends.* After the time limit ends for a year—

(1) If SSA records show an entry of self-employment income or wages for an employer for a period in that year, our records are conclusive evidence of your self-employment income in that year or the wages paid to you by that employer and the periods in which they were received unless one of the exceptions in § 404.822 applies;

(2) If SSA records show no entry of wages for an employer for a period in that year, our records are conclusive evidence that no wages were paid to

you by that employer in that period unless one of the exceptions in § 404.822 applies; and

(3) If SSA records show no entry of self-employment income for that year, our records are conclusive evidence that you did not receive self-employement income in that year unless the exception in § 404.822(b)(2) (i) or (iii) applies.

OBTAINING EARNINGS INFORMATION

§ 404.810 How to obtain a statement of earnings and a benefit estimate statement.

(a) *Right to a statement of earnings and a benefit estimate.* You or your legal representative or, after your death, your survivor or the legal representative of your estate may obtain a statement of your earnings as shown on our records at the time of the request. If you have a social security number and have wages or net earnings from self-employment, you may also request and receive an earnings statement that will include an estimate of the monthly old-age, disability, dependents', and survivors' insurance benefits potentially payable on your earnings record, together with a description of the benefits payable under the medicare program. You may request these statements by writing, calling, or visiting a social security office.

(b) *Contents of request.* When you request a statement of your earnings, we will ask you to complete a prescribed form, giving us your name, social security number, date of birth, and sex. You, your authorized representative or, after your death, your survivor or the legal representative of your estate will be asked to sign and date the form. If you are requesting an estimate of the monthly benefits potentially payable on your earnings record, we will also ask you to give us the amount of your earnings for the last year, an estimate of your earnings for the current year, an estimate of your earnings for future years before your planned retirement, and the age at which you plan to retire, so that we can give you a more realistic estimate of the benefits that may be payable on your record. A request for a statement of earnings and a benefit estimate not made on the prescribed form will be accepted if the request is in writing, is signed and dated by the appropriate individual noted above, and contains all the information that is requested on the prescribed form.

[57 FR 54918, Nov. 23, 1992]

§ 404.811 The statement of earnings and benefit estimates you requested.

(a) *General.* After receiving a request for a statement of earnings and the information we need to comply with the request, we will provide you or your authorized representative a statement of the earnings we have credited to your record at the time of your request. With the statement of earnings, we will include estimates of the benefits potentially payable on your record, unless you do not have the required credits (quarters of coverage) for any kind of benefit(s). (However, see paragraph (b)(3) of this section regarding the possibility of our estimating up to eight additional credits on your record.) If we do not provide a statement of earnings and an estimate of all the benefits potentially payable, or any other information you requested, we will explain why.

(b) *Contents of statement of earnings and benefit estimates.* The statement of your earnings and benefit estimates will contain the following information:

(1) Your social security taxed earnings as shown by our records as of the date of your request;

(2) An estimate of the social security and medicare hospital insurance taxes paid on your earnings (although we do not maintain such tax information);

(3) The number of credits, i.e., quarters of coverage, not exceeding 40, you have for both social security and medicare hospital insurance purposes, and the number you need to be eligible for social security and also for medicare hospital insurance coverage. If you do not already have the required credits (quarters of coverage) to be eligible to receive social security benefits and medicare hospital insurance coverage, we may include up to eight additional estimated credits (four per year) based on the earnings you told us you had for last year and this year that we have not yet entered on your record;

(4) A statement as to whether you meet the credits (quarters of coverage) requirements, as described in subpart B of this part, for each type of social security benefit when we prepare the benefit estimates, and also whether you are eligible for medicare hospital insurance coverage;

(5) Estimates of the monthly retirement (old-age), disability, dependents' and survivors' insurance benefits potentially payable on your record if you meet the credits (quarters of coverage) requirements. The benefit estimates we send you will be based partly on your stated earnings for last year (if not yet on your record), your estimate of your earnings for the current year and for future years before you plan to retire, and on the age at which you plan to retire. The estimate will include the retirement (old-age) insurance benefits you could receive at age 62 (or your current age if you are already over age 62), at full retirement age (currently age 65 to 67, depending on your year of birth) or at your current age if you are already over full retirement age, and at age 70;

(6) A description of the coverage under the medicare program;

(7) A reminder of your right to request a correction of your earnings record; and

(8) A remark that an annually updated statement is available on request.

[61 FR 18076, Apr. 24, 1996]

§ 404.812 Statement of earnings and benefit estimates sent without request.

(a) *Who will be sent a statement.* Unless one of the conditions in paragraph (b) of this section applies to you, we will send you, without request, a statement of earnings and benefit estimates if:

(1) You have a social security account number;

(2) You have wages or net earnings from self-employment on your social security record;

(3) You have attained age 25 or older, as explained in paragraph (c)(3) of this section; and

(4) We can determine your current mailing address.

(b) *Who will not be sent a statement.* We will not send you an unrequested statement if any of the following conditions apply:

(1) You do not meet one or more of the conditions of paragraph (a) of this section;

(2) Our records contain a notation of your death;

(3) You are entitled to benefits under title II of the Act;

(4) We have already sent you a statement, based on your request, in the fiscal year we selected you to receive an unrequested statement;

(5) We cannot obtain your address (see paragraph (c)(2) of this section); or

(6) We are correcting your social security earnings record when we select you to receive a statement of earnings and benefit estimates.

(c) *The selection and mailing process.* Subject to the provisions of paragraphs (a) and (b) of this section, we will use the following process for sending statements without requests:

(1) *Selection.* We will use our records of assigned social security account numbers to identify individuals to whom we will send statements.

(2) *Addresses.* If you are living in one of the 50 States or the District of Columbia, our current procedure is to get your address from individual taxpayer files of the Internal Revenue Service, as authorized by section 6103(m)(7) of the Internal Revenue Code (26 U.S.C. 6103(m)(7)). If you live in Puerto Rico, the Virgin Islands, or Guam, we will get your address from the taxpayer records of the place in which you live.

(3) *Age.* If you have attained age 60 on or before September 30, 1995, we will send you a statement by that date. If you attain age 60 on or after October 1, 1995 but no later than September 30, 1999, we will send you a statement in the fiscal year in which you attain age 60, or in an earlier year as resources allow. Also, we will inform you that an annually updated statement is available on request. Beginning October 1, 1999, we will send you a statement each year in which you are age 25 or older.

(4) *Ineligible.* If we do not send you a statement because one or more conditions in paragraph (b) of this section apply when you are selected, we will

send a statement in the first appropriate fiscal year thereafter in which you do qualify.

(5) *Undeliverable.* If the statement we send you is returned by the Post Office as undeliverable, we will not remail it.

(d) *Contents of statement of earnings and benefit estimates.* To prepare your statement and estimate your benefits, we will use the earnings in our records. If there are earnings recorded for you in either of the two years before the year in which you are selected to get a statement, we will use the later of these earnings as your earnings for the current year and future years when we estimate your benefits. In addition, if you do not already have the required credits (quarters of coverage) to be eligible to receive benefits, we will use that last recorded earnings amount to estimate up to eight additional credits (four per year) for last year and the current year if they are not yet entered on your record. If there are no earnings entered on your record in either of the two years preceding the year of selection, we will not estimate current and future earnings or additional credits for you. Your earnings and benefit estimates statement will contain the following information:

(1) Your social security taxed earnings as shown by our records as of the date we select you to receive a statement;

(2) An estimate of the social security and medicare hospital insurance taxes paid on your earnings (although we do not maintain such tax information);

(3) The number of credits, i.e., quarters of coverage, not exceeding 40 (as described in paragraph (d) of this section), that you have for both social security and medicare hospital insurance purposes, and the number you need to be eligible for social security benefits and also for medicare hospital insurance coverage;

(4) A statement as to whether you meet the credit (quarters of coverage) requirements, as described in subpart B of this part, for each type of social security benefit when we prepare the benefit estimates, and also whether you are eligible for medicare hospital insurance coverage;

(5) Estimates of the monthly retirement (old-age), disability, dependents' and survivors' insurance benefits potentially payable on your record if you meet the credits (quarters of coverage) requirements. If you are age 50 or older, the estimates will include the retirement (old-age) insurance benefits you could receive at age 62 (or your current age if you are already over age 62), at full retirement age (currently age 65 to 67, depending on your year of birth) or at your current age if you are already over full retirement age, and at age 70. If you are under age 50, instead of estimates, we may provide a general description of the benefits (including auxiliary benefits) that are available upon retirement;

(6) A description of the coverage provided under the medicare program;

(7) A reminder of your right to request a correction of your earnings record; and

(8) A remark that an annually updated statement is available on request.

[61 FR 18077, Apr. 24, 1996]

CORRECTING THE EARNINGS RECORD

§ 404.820 Filing a request for correction of the record of your earnings.

(a) *When to file a request for correction.* You or your survivor must file a request for correction of the record of your earnings within the time limit for the year being questioned unless one of the exceptions in § 404.822 applies.

(b) *Contents of a request.* (1) A request for correction of an earnings record must be in writing and must state that the record is incorrect.

(2) A request must be signed by you or your survivor or by a person who may sign an application for benefits for you or for your survivor as described in § 404.612.

(3) A request should state the period being questioned.

(4) A request should describe, or have attached to it, any available evidence which shows that the record of earnings is incorrect.

(c) *Where to file a request.* A request may be filed with an SSA employee at one of our offices or with an SSA employee who is authorized to receive a request at a place other than one of our offices. A request may be filed with the

Veterans Administration Regional Office in the Philippines or with any U.S. Foreign Service Office.

(d) *When a request is considered filed.* A request is considered filed on the day it is received by any of our offices, by an authorized SSA employee, by the Veterans Administration Regional Office in the Philippines, or by any U.S. Foreign Service Office. If using the date we receive a mailed request disadvantages the requester, we will use the date the request was mailed to us as shown by a U.S. postmark. If the postmark is unreadable or there is no postmark, we will consider other evidence of the date when the request was mailed.

(e) *Withdrawal of a request for correction.* A request for correction of SSA records of your earnings may be withdrawn as described in § 404.640.

(f) *Cancellation of a request to withdraw.* A request to withdraw a request for correction of SSA records of your earnings may be cancelled as described in § 404.641.

(g) *Determinations on requests.* When we receive a request described in this section, we will make a determination to grant or deny the request. If we deny the request, this determination may be appealed under the provisions of subpart J of this part.

§ 404.821 Correction of the record of your earnings before the time limit ends.

Before the time limit ends for any year, we will correct the record of your earnings for that year for any reason if satisfactory evidence shows SSA records are incorrect. We may correct the record as the result of a request filed under § 404.820 or we may correct it on our own.

§ 404.822 Correction of the record of your earnings after the time limit ends.

(a) *Generally.* After the time limit for any year ends, we may correct the record of your earnings for that year if satisfactory evidence shows SSA records are incorrect and any of the circumstances in paragraphs (b) through (e) of this section applies.

(b) *Correcting SSA records to agree with tax returns.* We will correct SSA records to agree with a tax return of wages or self-employment income to the extent that the amount of earnings shown in the return is correct.

(1) *Tax returns of wages.* We may correct the earnings record to agree with a tax return of wages or with a wage report of a State.

(2) *Tax returns of self-employment income*—(i) *Return filed before the time limit ended.* We may correct the earnings record to agree with a tax return of self-employment income filed before the end of the time limit.

(ii) *Return filed after time limit ended.* We may remove or reduce, but not increase, the amount of self-employment income entered on the earnings record to agree with a tax return of self-employment income filed after the time limit ends.

(iii) *Self-employment income entered in place of erroneously entered wages.* We may enter self-employment income for any year up to an amount erroneously entered in SSA records as wages but which was later removed from the records. However, we may enter self-employment income under this paragraph only if—

(A) An amended tax return is filed before the time limit ends for the year in which the erroneously entered wages were removed; or

(B) Net earnings from self-employment, which are not already entered in the record of your earnings, were included in a tax return filed before the end of the time limit for the year in which the erroneously entered wages were removed.

(c) *Written request for correction or application for benefits filed before the time limit ends*—(1) *Written request for correction.* We may correct an earnings record if you or your survivor files a request for correction before the time limit for that year ends. The request must state that the earnings record for that year is incorrect. However, we may not correct the record under this paragraph after our determination on the request becomes final.

(2) *Application for benefits.* We may correct an earnings record if an application is filed for monthly benefits or for a lump-sum death payment before the time limit for that year ends. However, we may not correct the record

under this paragraph after our determination on the application becomes final.

(3) See subpart J for the rules on the finality of determinations.

(d) *Transfer of wages to or from the Railroad Retirement Board*—(1) *Wages erroneously reported.* We may transfer to or from the records of the Railroad Retirement Board earnings which were erroneously reported to us or to the Railroad Retirement Board.

(2) *Earnings certified by Railroad Retirement Board.* We may enter earnings for railroad work under subpart O if the earnings are certified by the Railroad Retirement Board.

(e) *Other circumstances permitting correction*—(1) *Investigation started before time limit ends.* We may correct an earnings record if the correction is made as the result of an investigation started before, but completed after the time limit ends. An investigation is started when we take an affirmative step leading to a decision on a question about the earnings record, for example, an investigation is started when one SSA unit asks another unit to obtain additional information or evidence. We will remove or reduce earnings on the record under this paragraph only if we carried out the investigation as promptly as circumstances permitted.

(2) *Error apparent on face of records.* We may correct an earnings record to correct errors, such as mechanical or clerical errors, which can be identified and corrected without going beyond any of the pertinent SSA records.

(3) *Fraud.* We may change any entry which was entered on the earnings record as the result of fraud.

(4) *Entries for wrong person or period.* We may correct errors in SSA records resulting from earnings being entered for the wrong person or period.

(5) *Less than correct wages on SSA records.* We may enter wages paid to you by an employer for a period if no part of those wages or less than the correct amount of those wages is entered on SSA records.

(6) *Wage payments under a statute.* We may enter and allocate wages awarded to you for a period as the result of a determination or agreement approved by a court or administrative agency that enforces Federal or State statutes protecting your right to employment or wages.

[44 FR 38454, July 2, 1979, as amended at 57 FR 21600, May 21, 1992]

§ 404.823 Correction of the record of your earnings for work in the employ of the United States.

We may correct the record of your earnings to remove, reduce, or enter earnings for work in the employ of the United States only if—

(a) Correction is permitted under § 404.821 or § 404.822; and

(b) Any necessary determinations concerning the amount of remuneration paid for your work and the periods for which such remuneration was paid have been made as shown by—

(1) A tax return filed under section 3122 of the Internal Revenue Code (26 U.S.C. 3122); or

(2) A certification by the head of the Federal agency or instrumentality of which you have been an employee or his or her agent. A Federal instrumentality for these purposes includes a nonappropriated fund activity of the armed forces or Coast Guard.

[44 FR 38454, July 2, 1979, as amended at 55 FR 24891, June 19, 1990]

NOTICE OF REMOVAL OR REDUCTION OF AN ENTRY OF EARNINGS

§ 404.830 Notice of removal or reduction of your wages.

If we remove or reduce an amount of wages entered on the record of your earnings, we will notify you of this correction if we previously notified you of the amount of your wages for the period involved. We will notify your survivor if we previously notified you or your survivor of the amount of your earnings for the period involved.

§ 404.831 Notice of removal or reduction of your self-employment income.

If we remove or reduce an amount of self-employment income entered on the record of your earnings, we will notify you of this correction. We will notify your survivor if we previously notified you or your survivor of the amount of your earnings for the period involved.

Subpart J—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

AUTHORITY: Secs. 201(j), 204(f), 205(a), (b), (d)–(h), and (j), 221, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 401(j), 404(f), 405(a), (b), (d)–(h), and (j), 421, 425, and 902(a)(5)); 31 U.S.C. 3720A; sec. 5, Pub. L. 97–455, 96 Stat. 2500 (42 U.S.C. 405 note); secs. 5, 6(c)–(e), and 15, Pub. L. 98–460, 98 Stat. 1802 (42 U.S.C. 421 note).

SOURCE: 45 FR 52081, Aug. 5, 1980, unless otherwise noted.

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

§ 404.900 Introduction.

(a) *Explanation of the administrative review process.* This subpart explains the procedures we follow in determining your rights under title II of the Social Security Act. The regulations describe the process of administrative review and explain your right to judicial review after you have taken all the necessary administrative steps. These procedures apply also to persons claiming certain benefits under title XVIII of the Act (Medicare); see 42 CFR 405.701(c). The administrative review process consists of several steps, which usually must be requested within certain time periods and in the following order:

(1) *Initial determination.* This is a determination we make about your entitlement or your continuing entitlement to benefits or about any other matter, as discussed in § 404.902, that gives you a right to further review.

(2) *Reconsideration.* If you are dissatisfied with an initial determination, you may ask us to reconsider it.

(3) *Hearing before an administrative law judge.* If you are dissatisfied with the reconsideration determination, you may request a hearing before an administrative law judge.

(4) *Appeals Council review.* If you are dissatisfied with the decision of the administrative law judge, you may request that the Appeals Council review the decision.

(5) *Federal court review.* When you have completed the steps of the administrative review process listed in paragraphs (a)(1) through (a)(4) of this section, we will have made our final decision. If you are dissatisfied with our final decision, you may request judicial review by filing an action in a Federal district court.

(6) *Expedited appeals process.* At some time after your initial determination has been reviewed, if you have no dispute with our findings of fact and our application and interpretation of the controlling laws, but you believe that a part of the law is unconstitutional, you may use the expedited appeals process. This process permits you to go directly to a Federal district court so that the constitutional issue may be resolved.

(b) *Nature of the administrative review process.* In making a determination or decision in your case, we conduct the administrative review process in an informal, nonadversary manner. In each step of the review process, you may present any information you feel is helpful to your case. Subject to the limitations on Appeals Council consideration of additional evidence (see §§ 404.970(b) and 404.976(b)), we will consider at each step of the review process any information you present as well as all the information in our records. You may present the information yourself or have someone represent you, including an attorney. If you are dissatisfied with our decision in the review process, but do not take the next step within the stated time period, you will lose your right to further administrative review and your right to judicial review, unless you can show us that there was good cause for your failure to make a timely request for review.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 300, Jan 3, 1986; 51 FR 8808, Mar. 14, 1986; 52 FR 4004, Feb. 9, 1987]

§ 404.901 Definitions.

As used in this subpart:

Date you receive notice means 5 days after the date on the notice, unless you show us that you did not receive it within the 5-day period.

Decision means the decision made by an administrative law judge or the Appeals Council.

Determination means the initial determination or the reconsidered determination.

Remand means to return a case for further review.

Vacate means to set aside a previous action.

Waive means to give up a right knowingly and voluntarily.

We, us, or *our* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old age, disability, dependents' or survivors' benefits program.

§ 404.902 Administrative actions that are initial determinations.

Initial determinations are the determinations we make that are subject to administrative and judicial review. The initial determination will state the important facts and give the reasons for our conclusions. In the old age, survivors' and disability insurance programs, initial determinations include, but are not limited to, determinations about—

(a) Your entitlement or your continuing entitlement to benefits;

(b) Your reentitlement to benefits;

(c) The amount of your benefit;

(d) A recomputation of your benefit;

(e) A reduction in your disability benefits because you also receive benefits under a workmen's compensation law;

(f) A deduction from your benefits on account of work;

(g) A deduction from your disability benefits because you refuse to accept rehabilitation services;

(h) Termination of your benefits;

(i) Penalty deductions imposed because you failed to report certain events;

(j) Any overpayment or underpayment of your benefits;

(k) Whether an overpayment of benefits must be repaid to us;

(l) How an underpayment of benefits due a deceased person will be paid;

(m) The establishment or termination of a period of disability;

(n) A revision of your earnings record;

(o) Whether the payment of your benefits will be made, on your behalf, to a representative payee, unless you are under age 18, legally incompetent, or you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535);

(p) Your drug addiction or alcoholism;

(q) Who will act as your payee if we determine that representative payment will be made;

(r) An offset of your benefits under § 404.408b because you previously received supplemental security income payments for the same period;

(s) Whether your completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that you will not have to return to the disability benefit rolls and thus, whether your benefits may be continued even though you are not disabled;

(t) Nonpayment of your benefits under § 404.468 because of your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony;

(u) Whether or not you have a disabling impairment(s) as defined in § 404.1511;

(v) Nonpayment of your benefits under § 404.469 because you have not furnished us satisfactory proof of your Social Security number, or, if a Social Security number has not been assigned to you, you have not filed a proper application for one; and

(w) A claim for benefits under § 404.633 based on alleged misinformation.

[45 FR 52081, Aug. 5, 1980, as amended at 47 FR 4988, Feb. 3, 1982; 47 FR 31543, July 21, 1982; 49 FR 22272, May 29, 1984; 50 FR 20902, May 21, 1985; 56 FR 41790, Aug. 23, 1991; 59 FR 44925, Aug. 31, 1994; 60 FR 8147, Feb. 10, 1995]

§ 404.903 Administrative actions that are not initial determinations.

Administrative actions that are not initial determinations may be reviewed by us, but they are not subject to the administrative review process provided by this subpart, and they are not subject to judicial review. These actions include, but are not limited to, an action—

(a) Suspending benefits pending an investigation and determination of any factual issue relating to a deduction on account of work;

(b) Suspending benefits pending an investigation to determine if your disability has ceased;

(c) Denying a request to be made a representative payee;

(d) Certifying two or more family members for joint payment of benefits;

(e) Withholding less than the full amount of your monthly benefit to recover an overpayment;

(f) Determining the fee that may be charged or received by a person who has represented you in connection with a proceeding before us;

(g) Disqualifying or suspending a person from acting as your representative in a proceeding before us (See § 404.1745);

(h) Compromising, suspending or terminating collection of an overpayment under the Federal Claims Collection Act;

(i) Extending or not extending the time to file a report of earnings;

(j) Denying your request to extend the time period for requesting review of a determination or a decision;

(k) Denying your request to use the expedited appeals process;

(l) Denying your request to reopen a determination or a decision;

(m) Withholding temporarily benefits based on a wage earner's estimate of earnings to avoid creating an overpayment;

(n) Determining whether (and the amount of) travel expenses incurred are reimbursable in connection with proceedings before us;

(o) Denying your request to readjudicate your claim and apply an Acquiescence Ruling;

(p) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure (see § 404.523);

(q) Determining whether an organization may collect a fee from you for expenses it incurred in serving as your representative payee (see § 404.2040a);

(r) Declining under § 404.633(f) to make a determination on a claim for benefits based on alleged misinformation because one or more of the conditions specified in § 404.633(f) are not met;

(s) The assignment of a monthly payment day (see § 404.1807);

(t) Determining whether we will refer information about your overpayment to a consumer reporting agency (see §§ 404.527 and 422.305 of this chapter); and

(u) Determining whether we will refer your overpayment to the Department of the Treasury for collection by offset against Federal payments due you (see §§ 404.527 and 422.310 of this chapter).

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 8808, Mar. 14, 1986; 55 FR 1018, Jan. 11, 1990; 56 FR 52469, Oct. 21, 1991; 57 FR 23057, June 1, 1992; 59 FR 44925, Aug. 31, 1994; 62 FR 6120, Feb. 11, 1997; 62 FR 64278, Dec. 5, 1997]

§ 404.904 Notice of the initial determination.

We shall mail a written notice of the initial determination to you at your last known address. The reasons for the initial determination and the effect of the initial determination will be stated in the notice. The notice also informs you of the right to a reconsideration. We will not mail a notice if the beneficiary's entitlement to benefits has ended because of his or her death.

[51 FR 300, Jan. 3, 1986]

§ 404.905 Effect of an initial determination.

An initial determination is binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

[51 FR 300, Jan. 3, 1986]

§ 404.906 Testing modifications to the disability determination procedures.

(a) *Applicability and scope.* Notwithstanding any other provision in this part or part 422 of this chapter, we are establishing the procedures set out in this section to test modifications to our disability determination process. These modifications will enable us to test, either individually or in one or more combinations, the effect of: having disability claim managers assume primary responsibility for processing an application for disability benefits; providing persons who have applied for benefits based on disability with the opportunity for an interview with a decisionmaker when the decisionmaker

finds that the evidence in the file is insufficient to make a fully favorable determination or requires an initial determination denying the claim; having a single decisionmaker make the initial determination with assistance from medical consultants, where appropriate; and eliminating the reconsideration step in the administrative review process and having a claimant who is dissatisfied with the initial determination request a hearing before an administrative law judge. The model procedures we test will be designed to provide us with information regarding the effect of these procedural modifications and enable us to decide whether and to what degree the disability determination process would be improved if they were implemented on a national level.

(b) *Procedures for cases included in the tests.* Prior to commencing each test or group of tests in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe which model or combinations of models we intend to test, where the specific test site(s) will be, and the duration of the test(s). The individuals who participate in the test(s) will be randomly assigned to a test group in each site where the tests are conducted. Paragraphs (b) (1) through (4) of this section lists descriptions of each model.

(1) In the disability claim manager model, when you file an application for benefits based on disability, a disability claim manager will assume primary responsibility for the processing of your claim. The disability claim manager will be the focal point for your contacts with us during the claims intake process and until an initial determination on your claim is made. The disability claim manager will explain the disability programs to you, including the definition of disability and how we determine whether you meet all the requirements for benefits based on disability. The disability claim manager will explain what you will be asked to do throughout the claims process and how you can obtain information or assistance through him or her. The disability claim manager will also provide you with information regarding your right to representation, and he or she will provide you with appropriate referral sources for representation. The disability claim manager may be either a State agency employee or a Federal employee. In some instances, the disability claim manager may be assisted by other individuals.

(2) In the single decisionmaker model, the decisionmaker will make the disability determination and may also determine whether the other conditions for entitlement to benefits based on disability are met. The decisionmaker will make the disability determination after any appropriate consultation with a medical or psychological consultant. The medical or psychological consultant will not be required to sign the disability determination forms we use to have the State agency certify the determination of disability to us (see § 404.1615). However, before an initial determination is made that a claimant is not disabled in any case where there is evidence which indicates the existence of a mental impairment, the decisionmaker will make every reasonable effort to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment pursuant to our existing procedures (see § 404.1617). In some instances the decisionmaker may be the disability claim manager described in paragraph (b)(1) of this section. When the decisionmaker is a State agency employee, a team of individuals that includes a Federal employee will determine whether the other conditions for entitlement to benefits are met.

(3) In the predecision interview model, if the decisionmaker(s) finds that the evidence in your file is insufficient to make a fully favorable determination or requires an initial determination denying your claim, a predecision notice will be mailed to you. The notice will tell you that, before the decisionmaker(s) makes an initial determination about whether you are disabled, you may request a predecision interview with the decisionmaker(s). The notice will also tell you that you may submit additional evidence. You must request a predecision interview within 10 days after the date you receive the

predecision notice. You must also submit any additional evidence within 10 days after you receive the predecision notice. If you request a predecision interview, the decisionmaker(s) will conduct the predecision interview in person, by videoconference, or by telephone as the decisionmaker(s) determines is appropriate under the circumstances. If you make a late request for a predecision interview, or submit additional evidence late, but show in writing that you had good cause under the standards in § 404.911 for missing the deadline, the decisionmaker(s) will extend the deadline. If you do not request the predecision interview, or if you do not appear for a scheduled predecision interview and do not submit additional evidence, or if you do not respond to our attempts to communicate with you, the decisionmaker(s) will make an initial determination based upon the evidence in your file. If you identify additional evidence during the predecision interview, which was previously not available, the decisionmaker(s) will advise you to submit the evidence. If you are unable to do so, the decisionmaker(s) may assist you in obtaining it. The decisionmaker(s) also will advise you of the specific timeframes you have for submitting any additional evidence identified during the predecision interview. If you have no treating source(s) (see § 404.1502), or your treating source(s) is unable or unwilling to provide the necessary evidence, or there is a conflict in the evidence that cannot be resolved through evidence from your treating source(s), the decisionmaker(s) may arrange a consultative examination or resolve conflicts according to existing procedures (see § 404.1519a). If you attend the predecision interview, or do not attend the predecision interview but you submit additional evidence, the decisionmaker(s) will make an initial determination based on the evidence in your file, including the additional evidence you submit or the evidence obtained as a result of the predecision notice or interview, or both.

(4) In the reconsideration elimination model, we will modify the disability determination process by eliminating the reconsideration step of the administrative review process. If you receive an initial determination on your claim for benefits based on disability, and you are dissatisfied with the determination, we will notify you that you may request a hearing before an administrative law judge. If you request a hearing before an administrative law judge, we will apply our usual procedures contained in subpart J of this part.

[60 FR 20026, Apr. 24, 1995]

RECONSIDERATION

§ 404.907 Reconsideration—general.

If you are dissatisfied with the initial determination, reconsideration is the first step in the administrative review process that we provide, except that we provide the opportunity for a hearing before an administrative law judge as the first step for those situations described in §§ 404.930 (a)(6) and (a)(7), where you appeal an initial determination denying your request for waiver of adjustment or recovery of an overpayment (see § 404.506). If you are dissatisfied with our reconsidered determination, you may request a hearing before an administrative law judge.

[61 FR 56132, Oct. 31, 1996]

§ 404.908 Parties to a reconsideration.

(a) *Who may request a reconsideration.* If you are dissatisfied with the initial determination, you may request that we reconsider it. In addition, a person who shows in writing that his or her rights may be adversely affected by the initial determination may request a reconsideration.

(b) *Who are parties to a reconsideration.* After a request for the reconsideration, you and any person who shows in writing that his or her rights are adversely affected by the initial determination will be parties to the reconsideration.

§ 404.909 How to request reconsideration.

(a) We shall reconsider an initial determination if you or any other party to the reconsideration files a written request—

(1) Within 60 days after the date you receive notice of the initial determination (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(b) *Extension of time to request a reconsideration.* If you want a reconsideration of the initial determination but do not request one in time, you may ask us for more time to request a reconsideration. Your request for an extension of time must be in writing and must give the reasons why the request for reconsideration was not filed within the stated time period. If you show us that you had good cause for missing the deadline, we will extend the time period. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.911 Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you had good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

[45 FR 52081, Aug. 5, 1980, as amended at 59 FR 1634, Jan. 12, 1994]

§ 404.913 Reconsideration procedures.

(a) *Case review.* With the exception of the type of case described in paragraph (b) of this section, the reconsideration process consists of a case review. Under a case review procedure, we will give you and the other parties to the reconsideration an opportunity to present additional evidence to us. The official who reviews your case will then make a reconsidered determination based on all of this evidence.

(b) *Disability hearing.* If you have been receiving benefits based on disability and you request reconsideration of an initial or revised determination that, based on medical factors, you are not now disabled, we will give you and the other parties to the reconsideration an opportunity for a disability hearing. (See §§ 404.914 through 404.918.)

[51 FR 300, Jan. 3, 1986]

§ 404.914 Disability hearing—general.

(a) *Availability.* We will provide you with an opportunity for a disability hearing if:

(1) You have been receiving benefits based on a medical impairment that renders you disabled;

(2) We have made an initial or revised determination based on medical factors that you are not now disabled because your impairment:

(i) Has ceased;

(ii) Did not exist; or

(iii) Is no longer disabling; and

(3) You make a timely request for reconsideration of the initial or revised determination.

(b) *Scope.* The disability hearing will address only the initial or revised determination, based on medical factors, that you are not now disabled. Any other issues which arise in connection with your request for reconsideration will be reviewed in accordance with the reconsideration procedures described in § 404.913(a).

(c) *Time and place*—(1) *General.* Either the State agency or the Director of the Office of Disability Hearings or his or her delegate, as appropriate, will set the time and place of your disability hearing. We will send you a notice of the time and place of your disability hearing at least 20 days before the date of the hearing. You may be expected to travel to your disability hearing. (See §§ 404.999a–404.999d regarding reimbursement for travel expenses.)

(2) *Change of time or place.* If you are unable to travel or have some other reason why you cannot attend your disability hearing at the scheduled time or place, you should request at the earliest possible date that the time or place of your hearing be changed. We will change the time or place if there is good cause for doing so under the standards in § 404.936 (c) and (d).

(d) *Combined issues.* If a disability hearing is available to you under paragraph (a) of this section, and you file a new application for benefits while your request for reconsideration is still pending, we may combine the issues on both claims for the purpose of the disability hearing and issue a combined initial/reconsidered determination which is binding with respect to the common issues on both claims.

(e) *Definition.* For purposes of the provisions regarding disability hearings (§§ 404.914 through 404.918) *we, us* or *our* means the Social Security Administration or the State agency.

[51 FR 300, Jan. 3, 1986, as amended at 51 FR 8808, Mar. 14, 1986]

§ 404.915 Disability hearing—disability hearing officers.

(a) *General.* Your disability hearing will be conducted by a disability hearing officer who was not involved in making the determination you are appealing. The disability hearing officer will be an experienced disability examiner, regardless of whether he or she is appointed by a State agency or by the Director of the Office of Disability Hearings or his or her delegate, as described in paragraphs (b) and (c) below.

(b) *State agency hearing officers*—(1) *Appointment of State agency hearing officers.* If a State agency made the initial or revised determination that you are appealing, the disability hearing officer who conducts your disability hearing may be appointed by a State agency. If the disability hearing officer is appointed by a State agency, that individual will be employed by an adjudicatory unit of the State agency other than the adjudicatory unit which made the determination you are appealing.

(2) *State agency* defined. For purposes of this subpart, *State agency* means the adjudicatory component in the State which issues disability determinations.

(c) *Federal hearing officers.* The disability hearing officer who conducts your disability hearing will be appointed by the Director of the Office of Disability Hearings or his or her delegate if:

(1) A component of our office other than a State agency made the determination you are appealing; or

(2) The State agency does not appoint a disability hearing officer to conduct your disability hearing under paragraph (b) of this section.

[51 FR 301, Jan. 3, 1986]

§ 404.916 Disability hearing—procedures.

(a) *General.* The disability hearing will enable you to introduce evidence and present your views to a disability

hearing officer if you are dissatisfied with an initial or revised initial determination, based on medical factors, that you are not now disabled as described in § 404.914(a)(2).

(b) *Your procedural rights.* We will advise you that you have the following procedural rights in connection with the disability hearing process:

(1) You may request that we assist you in obtaining pertinent evidence for your disability hearing and, if necessary, that we issue a subpoena to compel the production of certain evidence or testimony. We will follow subpoena procedures similar to those described in § 404.950(d) for the administrative law judge hearing process;

(2) You may have a representative at the hearing appointed under subpart R of this part, or you may represent yourself;

(3) You or your representative may review the evidence in your case file, either on the date of your hearing or at an earlier time at your request, and present additional evidence;

(4) You may present witnesses and question any witnesses at the hearing;

(5) You may waive your right to appear at the hearing. If you do not appear at the hearing, the disability hearing officer will prepare and issue a written reconsidered determination based on the information in your case file.

(c) *Case preparation.* After you request reconsideration, your case file will be reviewed and prepared for the hearing. This review will be conducted in the component of our office (including a State agency) that made the initial or revised determination, by personnel who were not involved in making the initial or revised determination. Any new evidence you submit in connection with your request for reconsideration will be included in this review. If necessary, further development of the evidence, including arrrangements for medical examinations, will be undertaken by this component. After the case file is prepared for the hearing, it will be forwarded by this component to the disability hearing officer for a hearing. If necessary, the case file may be sent back to this component at any time prior to the issuance of the reconsidered determination for additional development. Under paragraph (d) of this section, this component has the authority to issue a favorable reconsidered determination at any time in its development process.

(d) *Favorable reconsideration determination without a hearing.* If all the evidence in your case file supports a finding that you are now disabled, either the component that prepares your case for hearing under paragraph (c) or the disability hearing officer will issue a written favorable reconsideration determination, even if a disability hearing has not yet been held.

(e) *Opportunity to submit additional evidence after the hearing.* At your request, the disability hearing officer may allow up to 15 days after your disability hearing for receipt of evidence which is not available at the hearing, if:

(1) The disability hearing officer determines that the evidence has a direct bearing on the outcome of the hearing; and

(2) The evidence could not have been obtained before the hearing.

(f) *Opportunity to review and comment on evidence obtained or developed by us after the hearing.* If, for any reason, additional evidence is obtained or developed by us after your disability hearing, and all evidence taken together can be used to support a reconsidered determination that is unfavorable to you with regard to the medical factors of eligibility, we will notify you, in writing, and give you an opportunity to review and comment on the additional evidence. You will be given 10 days from the date you receive our notice to submit your comments (in writing or, in appropriate cases, by telephone), unless there is good cause for granting you additional time, as illustrated by the examples in § 404.911(b). Your comments will be considered before a reconsidered determination is issued. If you believe that it is necessary to have further opportunity for a hearing with respect to the additional evidence, a supplementary hearing may be scheduled at your request. Otherwise, we will ask for your written comments on

the additional evidence, or, in appropriate cases, for your telephone comments.

[51 FR 301, Jan. 3, 1986]

§ 404.917 Disability hearing—disability hearing officer's reconsidered determination.

(a) *General.* The disability hearing officer who conducts your disability hearing will prepare and will also issue a written reconsidered determination, unless:

(1) The disability hearing officer sends the case back for additional development by the component that prepared the case for the hearing, and that component issues a favorable determination, as permitted by § 404.916(c);

(2) It is determined that you are engaging in substantial gainful activity and that you are therefore not disabled; or

(3) The reconsidered determination prepared by the disability hearing officer is reviewed under § 404.918.

(b) *Content.* The disability hearing officer's reconsidered determination will give the findings of fact and the reasons for the reconsidered determination. The reconsidered determination must be based on evidence offered at the disability hearing or otherwise included in the case file.

(c) *Notice.* We will mail you and the other parties a notice of reconsidered determination in accordance with § 404.922.

(d) *Effect.* The disability hearing officer's reconsidered determination, or, if it is changed under § 404.918, the reconsidered determination that is issued by the Director of the Office of Disability Hearings or his or her delegate, is binding in accordance with § 404.921, subject to the exceptions specified in that section.

[51 FR 302, Jan. 3, 1986]

§ 404.918 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.

(a) *General.* The Director of the Office of Disability Hearings or his or her delegate may select a sample of disability hearing officers' reconsidered determinations, before they are issued, and review any such case to determine its correctness on any grounds he or she deems appropriate. The Director or his or her delegate shall review any case within the sample if:

(1) There appears to be an abuse of discretion by the hearing officer;

(2) There is an error of law; or

(3) The action, findings or conclusions of the disability hearing officer are not supported by substantial evidence.

If the review indicates that the reconsidered determination prepared by the disability hearing officer is correct, it will be dated and issued immediately upon completion of the review. If the reconsidered determination prepared by the disability hearing officer is found by the Director or his or her delegate to be deficient, it will be changed as described in paragraph (b) of this section.

(b) *Methods of correcting deficiencies in the disability hearing officer's reconsidered determination.* If the reconsidered determination prepared by the disability hearing officer is found by the Director or his or her delegate to be deficient, the Director of the Office of Disability Hearings or his or her delegate will take appropriate action to assure that the deficiency is corrected before a reconsidered determination is issued. The action taken by the Director or his or her delegate will take one of two forms:

(1) The Director or his or her delegate may return the case file either to the component responsible for preparing the case for hearing or to the disability hearing officer, for appropriate further action; or

(2) The Director or his or her delegate may issue a written reconsidered determination which corrects the deficiency.

(c) *Further action on your case if it is sent back by the Director or his or her delegate either to the component that prepared your case for hearing or to the disability hearing officer.* If the Director of the Office of Disability Hearings or his or her delegate sends your case back either to the component responsible for preparing the case for hearing or to the disability hearing officer for appropriate further action, as provided in paragraph (b)(1) of this section, any additional proceedings in your case will

be governed by the disability hearing procedures described in § 404.916(f) or if your case is returned to the disability hearing officer and an unfavorable determination is indicated, a supplementary hearing may be scheduled for you before a reconsidered determination is reached in your case.

(d) *Opportunity to comment before the Director or his or her delegate issues a reconsidered determination that is unfavorable to you.* If the Director of the Office of Disability Hearings or his or her delegate proposes to issue a reconsidered determination as described in paragraph (b)(2) of this section, and that reconsidered determination is unfavorable to you, he or she will send you a copy of the proposed reconsidered determination with an explanation of the reasons for it, and will give you an opportunity to submit written comments before it is issued. At your request, you will also be given an opportunity to inspect the pertinent materials in your case file, including the reconsidered determination prepared by the disability hearing officer, before submitting your comments. You will be given 10 days from the date you receive the Director's notice of proposed action to submit your written comments, unless additional time is necessary to provide access to the pertinent file materials or there is good cause for providing more time, as illustrated by the examples in § 404.911(b). The Director or his or her delegate will consider your comments before taking any further action on your case.

[51 FR 302, Jan. 3, 1986]

§ 404.919 Notice of another person's request for reconsideration.

If any other person files a request for reconsideration of the initial determination in your case, we shall notify you at your last known address before we reconsider the initial determination. We shall also give you an opportunity to present any evidence you think helpful to the reconsidered determination.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

§ 404.920 Reconsidered determination.

After you or another person requests a reconsideration, we shall review the evidence considered in making the initial determination and any other evidence we receive. We shall make our determination based on this evidence.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

§ 404.921 Effect of a reconsidered determination.

The reconsidered determination is binding unless—

(a) You or any other party to the reconsideration requests a hearing before an administrative law judge within the stated time period and a decision is made;

(b) The expedited appeals process is used; or

(c) The reconsidered determination is revised.

[51 FR 302, Jan. 3, 1986]

§ 404.922 Notice of a reconsidered determination.

We shall mail a written notice of the reconsidered determination to the parties at their last known address. We shall state the specific reasons for the determination and tell you and any other parties of the right to a hearing. If it is appropriate, we will also tell you and any other parties how to use the expedited appeals process.

[45 FR 52081, Aug. 5, 1980. Redesignated at 51 FR 302, Jan. 3, 1986]

EXPEDITED APPEALS PROCESS

§ 404.923 Expedited appeals process—general.

By using the expedited appeals process you may go directly to a Federal district court without first completing the administrative review process that is generally required before the court will hear your case.

§ 404.924 When the expedited appeals process may be used.

You may use the expedited appeals process if all of the following requirements are met:

(a) We have made an initial and a reconsidered determination; an administrative law judge has made a hearing

decision; or Appeals Council review has been requested, but a final decision has not been issued.

(b) You are a party to the reconsidered determination or the hearing decision.

(c) You have submitted a written request for the expedited appeals process.

(d) You have claimed, and we agree, that the only factor preventing a favorable determination or decision is a provision in the law that you believe is unconstitutional.

(e) If you are not the only party, all parties to the determination or decision agree to request the expedited appeals process.

§ 404.925 How to request expedited appeals process.

(a) *Time of filing request.* You may request the expedited appeals process—

(1) Within 60 days after the date you receive notice of the reconsidered determination (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At any time after you have filed a timely request for a hearing but before you receive notice of the administrative law judge's decision;

(3) Within 60 days after the date you receive a notice of the administrative law judge's decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (c) of this section); or

(4) At any time after you have filed a timely request for Appeals Council review, but before you receive notice of the Appeals Council's action.

(b) *Place of filing request.* You may file a written request for the expedited appeals process at one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(c) *Extension of time to request expedited appeals process.* If you want to use the expedited appeals process but do not request it within the stated time period, you may ask for more time to submit your request. Your request for an extension of time must be in writing and must give the reasons why the request for the expedited appeals process was not filed within the stated time period. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.926 Agreement in expedited appeals process.

If you meet all the requirements necessary for the use of the expedited appeals process, our authorized representative shall prepare an agreement. The agreement must be signed by you, by every other party to the determination or decision and by our authorized representative. The agreement must provide that—

(a) The facts in your claim are not in dispute;

(b) The sole issue in dispute is whether a provision of the Act that applies to your case is unconstitutional;

(c) Except for your belief that a provision of the Act is unconstitutional, you agree with our interpretation of the law;

(d) If the provision of the Act that you believe is unconstitutional were not applied to your case, your claim would be allowed; and

(e) Our determination or the decision is final for the purpose of seeking judicial review.

§ 404.927 Effect of expedited appeals process agreement.

After an expedited appeals process agreement is signed, you will not need to complete the remaining steps of the administrative review process. Instead, you may file an action in a Federal district court within 60 days after the date you receive notice (a signed copy of the agreement will be mailed to you and will constitute notice) that the agreement has been signed by our authorized representative.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984]

§ 404.928 Expedited appeals process request that does not result in agreement.

If you do not meet all of the requirements necessary to use the expedited appeals process, we shall tell you that

your request to use this process is denied and that your request will be considered as a request for a hearing or Appeals Council review, whichever is appropriate.

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

§ 404.929 Hearing before an administrative law judge—general.

If you are dissatisfied with one of the determinations or decisions listed in § 404.930 you may request a hearing. The Associate Commissioner for Hearings and Appeals, or his or her delegate, shall appoint an administrative law judge to conduct the hearing. If circumstances warrant, the Associate Commissioner, or his or her delegate, may assign your case to another administrative law judge. At the hearing you may appear in person, submit new evidence, examine the evidence used in making the determination or decision under review, and present and question witnesses. The administrative law judge who conducts the hearing may ask you questions. He or she shall issue a decision based on the hearing record. If you waive your right to appear at the hearing, the administrative law judge will make a decision based on the evidence that is in the file and any new evidence that may have been submitted for consideration.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 302, Jan. 3, 1986]

§ 404.930 Availability of a hearing before an administrative law judge.

(a) You or another party may request a hearing before an administrative law judge if we have made—

(1) A reconsidered determination;

(2) A revised determination of an initial determination, unless the revised determination concerns the issue of whether, based on medical factors, you are disabled;

(3) A reconsideration of a revised initial determination concerning the issue of whether, based on medical factors, you are disabled;

(4) A revised reconsidered determination;

(5) A revised decision based on evidence not included in the record on which the prior decision was based;

(6) An initial determination denying waiver of adjustment or recovery of an overpayment based on a personal conference (see § 404.506); or

(7) An initial determination denying waiver of adjustment or recovery of an overpayment based on a review of the written evidence of record (see § 404.506), and the determination was made concurrent with, or subsequent to, our reconsideration determination regarding the underlying overpayment but before an administrative law judge holds a hearing.

(b) We will hold a hearing only if you or another party to the hearing file a written request for a hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 61 FR 56132, Oct. 31, 1996]

§ 404.932 Parties to a hearing before an administrative law judge.

(a) *Who may request a hearing.* You may request a hearing if a hearing is available under § 404.930. In addition, a person who shows in writing that his or her rights may be adversely affected by the decision may request a hearing.

(b) *Who are parties to a hearing.* After a request for a hearing is made, you, the other parties to the initial, reconsidered, or revised determination, and any other person who shows in writing that his or her rights may be adversely affected by the hearing, are parties to the hearing. In addition, any other person may be made a party to the hearing if his or her rights may be adversely affected by the decision, and the administrative law judge notifies the person to appear at the hearing or to present evidence supporting his or her interest.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.933 How to request a hearing before an administrative law judge.

(a) *Written request.* You may request a hearing by filing a written request. You should include in your request—

(1) The name and social security number of the wage earner;

(2) The reasons you disagree with the previous determination or decision;

(3) A statement of additional evidence to be submitted and the date you will submit it; and

(4) The name and address of any designated representative.

(b) *When and where to file.* The request must be filed—

(1) Within 60 days after the date you receive notice of the previous determination or decision (or within the extended time period if we extend the time as provided in paragraph (c) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board for persons having 10 or more years of service in the railroad industry.

(c) *Extension of time to request a hearing.* If you have a right to a hearing but do not request one in time, you may ask for more time to make your request. The request for an extension of time must be in writing and it must give the reasons why the request for a hearing was not filed within the stated time period. You may file your request for an extension of time at one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.935 Submitting evidence prior to a hearing before an administrative law judge.

If possible, the evidence or a summary of evidence you wish to have considered at the hearing should be submitted to the administrative law judge with the request for hearing or within 10 days after filing the request. Each party shall make every effort to be sure that all material evidence is received by the administrative law judge or is available at the time and place set for the hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.936 Time and place for a hearing before an administrative law judge.

(a) The administrative law judge sets the time and place for the hearing. He or she may change the time and place, if it is necessary. After sending the parties reasonable notice of the proposed action, the administrative law judge may adjourn or postpone the hearing or reopen it to receive additional evidence any time before he or she notifies the parties of a hearing decision. Hearings are held in the 50 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, the Commonwealth of Puerto Rico and the Virgin Islands.

(b) If you object to the time or place of the hearing, you must notify the administrative law judge at the earliest possible opportunity before the time set for the hearing. You must state the reason for your objection and state the time and place you want the hearing to be held. If at all possible, the request should be in writing. The administrative law judge will change the time or place of the hearing if you have good cause, as determined under paragraphs (c) and (d) of this section. § 404.938 provides procedures we will follow when you do not respond to a notice of hearing.

(c) The administrative law judge will find good cause for changing the time or place of your scheduled hearing, and will reschedule your hearing if your reason is one of the following circumstances and is supported by the evidence:

(1) You or your representative are unable to attend or to travel to the scheduled hearing because of a serious physical or mental condition, incapacitating injury, or death in the family; or

(2) Severe weather conditions make it impossible to travel to the hearing.

(d) In determining whether good cause exists in circumstances other than those set out in paragraph (c) of this section, the administrative law judge will consider your reason for requesting the change, the facts supporting it, and the impact of the proposed change on the efficient administration of the hearing process. Factors affecting the impact of the change include, but are not limited to, the effect on the processing of other scheduled hearings, delays which might occur in rescheduling your hearing, and whether any prior changes were granted to you. Examples of such other circumstances, which you might give for requesting a change in the time or

place of the hearing, include, but are not limited to, the following:

(1) You have attempted to obtain a representative but need additional time;

(2) Your representative was appointed within 30 days of the scheduled hearing and needs additional time to prepare for the hearing;

(3) Your representative has a prior commitment to be in court or at another administrative hearing on the date scheduled for the hearing;

(4) A witness who will testify to facts material to your case would be unavailable to attend the scheduled hearing and the evidence cannot be otherwise obtained;

(5) Transportation is not readily available for you to travel to the hearing;

(6) You live closer to another hearing site; or

(7) You are unrepresented, and you are unable to respond to the notice of hearing because of any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

[45 FR 52081, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 303, Jan. 3, 1986; 59 FR 1634, Jan. 12, 1994]

§ 404.938 Notice of a hearing before an administrative law judge.

After the administrative law judge sets the time and place of the hearing, notice of the hearing will be mailed to the parties at their last known addresses, or given by personal service, unless you have indicated in writing that you do not wish to receive this notice. The notice will be mailed or served at least 20 days before the hearing. The notice of hearing will contain a statement of the specific issues to be decided and tell you that you may designate a person to represent you during the proceedings. The notice will also contain an explanation of the procedures for requesting a change in the time or place of your hearing, a reminder that if you fail to appear at your scheduled hearing without good cause the ALJ may dismiss your hearing request, and other information about the scheduling and conduct of your hearing. If you or your representative do not acknowledge receipt of the notice of hearing, we will attempt to contact you for an explanation. If you tell us that you did not receive the notice of hearing, an amended notice will be sent to you by certified mail. See § 404.936 for the procedures we will follow in deciding whether the time or place of your scheduled hearing will be changed if you do not respond to the notice of hearing.

[50 FR 21438, May 24, 1985, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.939 Objections to the issues.

If you object to the issues to be decided upon at the hearing, you must notify the administrative law judge in writing at the earliest possible opportunity before the time set for the hearing. You must state the reasons for your objections. The administrative law judge shall make a decision on your objections either in writing or at the hearing.

§ 404.940 Disqualification of the administrative law judge.

An administrative law judge shall not conduct a hearing if he or she is prejudiced or partial with respect to any party or has any interest in the matter pending for decision. If you object to the administrative law judge who will conduct the hearing, you must notify the administrative law judge at your earliest opportunity. The administrative law judge shall consider your objections and shall decide whether to proceed with the hearing or withdraw. If he or she withdraws, the Associate Commissioner for Hearings and Appeals, or his or her delegate, will appoint another administrative law judge to conduct the hearing. If the administrative law judge does not withdraw, you may, after the hearing, present your objections to the Appeals Council as reasons why the hearing decision should be revised or a new hearing held before another administrative law judge.

§ 404.941 Prehearing case review.

(a) *General.* After a hearing is requested but before it is held, we may, for the purposes of a prehearing case review, forward the case to the component of our office (including a State

agency) that issued the determination being reviewed. That component will decide whether the determination may be revised. A revised determination may be wholly or partially favorable to you. A prehearing case review will not delay the scheduling of a hearing unless you agree to continue the review and delay the hearing. If the prehearing case review is not completed before the date of the hearing, the case will be sent to the administrative law judge unless a favorable revised determination is in process or you and the other parties to the hearing agree in writing to delay the hearing until the review is completed.

(b) *When a prehearing case review may be conducted.* We may conduct a prehearing case review if—

(1) Additional evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulation; or

(4) There is an error in the file or some other indication that the prior determination may be revised.

(c) *Notice of a prehearing revised determination.* If we revise the determination in a prehearing case review, we shall mail written notice of the revised determination to all parties at their last known address. We shall state the basis for the revised determination and advise all parties of their right to request a hearing on the revised determination within 60 days after the date or receiving this notice.

(d) *Revised determination wholly favorable.* If the revised determination is wholly favorable to you, we shall tell you in the notice that the administrative law judge will dismiss the hearing request unless a party requests that the hearing proceed. A request to continue must be made in writing within 30 days after the date the notice of the revised determination is mailed.

(e) *Revised determination partially favorable.* If the revised determination is partially favorable to you, we shall tell you in the notice what was not favorable. We shall also tell you that the hearing you requested will be held unless you, the parties to the revised determination and the parties to the hearing tell us that all parties agree to dismiss the hearing request.

§ 404.942 Prehearing proceedings and decisions by attorney advisors.

(a) *General.* After a hearing is requested but before it is held, an attorney advisor in our Office of Hearings and Appeals may conduct prehearing proceedings as set out in paragraph (c) of this section. If upon the completion of these proceedings, a decision that is wholly favorable to you and all other parties may be made, an attorney advisor, instead of an administrative law judge, may issue such a decision. The conduct of the prehearing proceedings by the attorney advisor will not delay the scheduling of a hearing. If the prehearing proceedings are not completed before the date of the hearing, the case will be sent to the administrative law judge unless a wholly favorable decision is in process or you and all other parties to the hearing agree in writing to delay the hearing until the proceedings are completed.

(b) *When prehearing proceedings may be conducted by an attorney advisor.* An attorney advisor may conduct prehearing proceedings if you have filed a claim for benefits based on disability and—

(1) New and material evidence is submitted;

(2) There is an indication that additional evidence is available;

(3) There is a change in the law or regulations; or

(4) There is an error in the file or some other indication that a wholly favorable decision may be issued.

(c) *Nature of the prehearing proceedings that may be conducted by an attorney advisor.* As part of the prehearing proceedings, the attorney advisor, in addition to reviewing the existing record, may—

(1) Request additional evidence that may be relevant to the claim, including medical evidence; and

(2) If necessary to clarify the record for the purpose of determining if a wholly favorable decision is warranted, schedule a conference with the parties.

(d) *Notice of a decision by an attorney advisor.* If the attorney advisor issues a wholly favorable decision under this section, we shall mail a written notice of the decision to all parties at their last known address. We shall state the basis for the decision and advise all

parties that an administrative law judge will dismiss the hearing request unless a party requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date the notice of the decision of the attorney advisor is mailed.

(e) *Effect of actions under this section.* If under this section, an administrative law judge dismisses a request for a hearing, the dismissal is binding in accordance with § 404.959 unless it is vacated by an administrative law judge or the Appeals Council pursuant to § 404.960. A decision made by an attorney advisor under this section is binding unless—

(1) A party files a request to proceed with the hearing pursuant to paragraph (d) of this section and an administrative law judge makes a decision;

(2) The Appeals Council reviews the decision on its own motion pursuant to § 404.969 as explained in paragraph (f)(3) of this section; or

(3) The decision of the attorney advisor is revised under the procedures explained in § 404.987.

(f) *Ancillary provisions.* For the purposes of the procedures authorized by this section, the regulations of part 404 shall apply to—

(1) Authorize an attorney advisor to exercise the functions performed by an administrative law judge under §§ 404.1520a and 404.1546;

(2) Define the term ''decision'' to include a decision made by an attorney advisor, as well as the decisions identified in § 404.901; and

(3) Make the decision of an attorney advisor subject to review by the Appeals Council under § 404.969 if an administrative law judge dismisses the request for a hearing following issuance of the decision, and the Appeals Council decides to review the decision of the attorney advisor anytime within 60 days after the date of the dismissal.

(g) *Sunset provision.* The provisions of this section will no longer be effective on April 2, 2001.

[60 FR 34131, June 30, 1995, as amended at 63 FR 35516, June 30, 1998; 64 FR 13678, Mar. 22, 1999; 64 FR 51893, Sept. 27, 1999]

§ 404.943 Responsibilities of the adjudication officer.

(a)(1) *General.* Under the procedures set out in this section we will test modifications to the procedures we follow when you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether you are under a disability as defined in § 404.1505 is at issue. These modifications will enable us to test the effect of having an adjudication officer be your primary point of contact after you file a hearing request and before you have a hearing with an administrative law judge. The tests may be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The adjudication officer, working with you and your representative, if any, will identify issues in dispute, develop evidence, conduct informal conferences, and conduct any other prehearing proceeding as may be necessary. The adjudication officer has the authority to make a decision wholly favorable to you if the evidence so warrants. If the adjudication officer does not make a decision on your claim, your hearing request will be assigned to an administrative law judge for further proceedings.

(2) *Procedures for cases included in the tests.* Prior to commencing tests of the adjudication officer position in selected site(s), we will publish a notice in the FEDERAL REGISTER. The notice will describe where the specific test site(s) will be and the duration of the test(s). We will also state whether the tests of the adjudication officer position in each site will be conducted alone, or in combination with the tests of the modifications to the disability determination procedures which we conduct under § 404.906. The individuals who participate in the test(s) will be assigned randomly to a test group in each site where the tests are conducted.

(b)(1) *Prehearing procedures conducted by an Adjudication Officer.* When you file a request for a hearing before an administrative law judge in connection with a claim for benefits based on disability where the question of whether

you are under a disability as defined in § 404.1505 is at issue, the adjudication officer will conduct an interview with you. The interview may take place in person, by telephone, or by videoconference, as the adjudication officer determines is appropriate under the circumstances of your case. If you file a request for an extension of time to request a hearing in accordance with § 404.933(c), the adjudication officer may develop information on, and may decide where the adjudication officer issues a wholly favorable decision to you that you had good cause for missing the deadline for requesting a hearing. To determine whether you had good cause for missing the deadline, the adjudication officer will use the standards contained in § 404.911.

(2) *Representation.* The adjudication officer will provide you with information regarding the hearing process, including your right to representation. As may be appropriate, the adjudication officer will provide you with referral sources for representation, and give you copies of necessary documents to facilitate the appointment of a representative. If you have a representative, the adjudication officer will conduct an informal conference with the representative, in person or by telephone, to identify the issues in dispute and prepare proposed written agreements for the approval of the administrative law judge regarding those issues which are not in dispute and those issues proposed for the hearing. If you decide to proceed without representation, the adjudication officer may hold an informal conference with you. If you obtain representation after the adjudication officer has concluded that your case is ready for a hearing, the administrative law judge will return your case to the adjudication officer who will conduct an informal conference with you and your representative.

(3) *Evidence.* You, or your representative, may submit, or may be asked to obtain and submit, additional evidence to the adjudication officer. As the adjudication officer determines is appropriate under the circumstances of your case, the adjudication officer may refer the claim for further medical or vocational evidence.

(4) *Referral for a hearing.* The adjudication officer will refer the claim to the administrative law judge for further proceedings when the development of evidence is complete, and you or your representative agree that a hearing is ready to be held. If you or your representative are unable to agree with the adjudication officer that the development of evidence is complete, the adjudication officer will note your disagreement and refer the claim to the administrative law judge for further proceedings. At this point, the administrative law judge conducts all further hearing proceedings, including scheduling and holding a hearing (§ 404.936), considering any additional evidence or arguments submitted (§§ 404.935, 404.944, 404.949, 404.950), and issuing a decision or dismissal of your request for a hearing, as may be appropriate (§§ 404.948, 404.953, 404.957). In addition, if the administrative law judge determines on or before the date of your hearing that the development of evidence is not complete, the administrative law judge may return the claim to the adjudication officer to complete the development of the evidence and for such other action as necessary.

(c)(1) *Wholly favorable decisions issued by an adjudication officer.* If, after a hearing is requested but before it is held, the adjudication officer decides that the evidence in your case warrants a decision which is wholly favorable to you, the adjudication officer may issue such a decision. For purposes of the tests authorized under this section, the adjudication officer's decision shall be considered to be a decision as defined in § 404.901. If the adjudication officer issues a decision under this section, it will be in writing and will give the findings of fact and the reasons for the decision. The adjudication officer will evaluate the issues relevant to determining whether or not you are disabled in accordance with the provisions of the Social Security Act, the rules in this part and part 422 of this chapter and applicable Social Security Rulings. For cases in which the adjudication officer issues a decision, he or she may determine your residual functional capacity in the same manner that an administrative law judge is

authorized to do so in § 404.1546. The adjudication officer may also evaluate the severity of your mental impairments in the same manner that an administrative law judge is authorized to do so under § 404.1520a. The adjudication officer's decision will be based on the evidence which is included in the record and, subject to paragraph (c)(2) of this section, will complete the actions that will be taken on your request for hearing. A copy of the decision will be mailed to all parties at their last known address. We will tell you in the notice that the administrative law judge will not hold a hearing unless a party to the hearing requests that the hearing proceed. A request to proceed with the hearing must be made in writing within 30 days after the date the notice of the decision of the adjudication officer is mailed.

(2) *Effect of a decision by an adjudication officer.* A decision by an adjudication officer which is wholly favorable to you under this section, and notification thereof, completes the administrative action on your request for hearing and is binding on all parties to the hearing and not subject to further review, unless—

(i) You or another party requests that the hearing continue, as provided in paragraph (c)(1) of this section;

(ii) The Appeals Council decides to review the decision on its own motion under the authority provided in § 404.969;

(iii) The decision is revised under the procedures explained in §§ 404.987 through 404.989; or

(iv) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

(3) *Fee for a representative's services.* The adjudication officer may authorize a fee for your representative's services if the adjudication officer makes a decision on your claim that is wholly favorable to you, and you are represented. The actions of, and any fee authorization made by, the adjudication officer with respect to representation will be made in accordance with the provisions of subpart R of this part.

(d) *Who may be an adjudication officer.* The adjudication officer described in this section may be an employee of the Social Security Administration or a State agency that makes disability determinations for us.

[60 FR 47475, Sept. 13, 1995]

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

§ 404.944 Administrative law judge hearing procedures—general.

A hearing is open to the parties and to other persons the administrative law judge considers necessary and proper. At the hearing, the administrative law judge looks fully into the issues, questions you and the other witnesses, and accepts as evidence any documents that are material to the issues. The administrative law judge may stop the hearing temporarily and continue it at a later date if he or she believes that there is material evidence missing at the hearing. The administrative law judge may also reopen the hearing at any time before he or she mails a notice of the decision in order to receive new and material evidence. The administrative law judge may decide when the evidence will be presented and when the issues will be discussed.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.946 Issues before an administrative law judge.

(a) *General.* The issues before the administrative law judge include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in your favor. However, if evidence presented before or during the hearing causes the administrative law judge to question a fully favorable determination, he or she will notify you and will consider it an issue at the hearing.

(b) *New issues*—(1) *General.* The administrative law judge may consider a new issue at the hearing if he or she notifies you and all the parties about the new issue any time after receiving the hearing request and before mailing notice of the hearing decision. The administrative law judge or any party may raise a new issue; an issue may be raised even though it arose after the request for a hearing and even though it has not been considered in an initial

or reconsidered determination. However, it may not be raised if it involves a claim that is within the jurisdiction of a State agency under a Federal-State agreement concerning the determination of disability.

(2) *Notice of a new issue.* The administrative law judge shall notify you and any other party if he or she will consider any new issue. Notice of the time and place of the hearing on any new issues will be given in the manner described in § 404.938, unless you have indicated in writing that you do not wish to receive the notice.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.948 Deciding a case without an oral hearing before an administrative law judge.

(a) *Decision wholly favorable.* If the evidence in the hearing record supports a finding in favor of you and all the parties on every issue, the administrative law judge may issue a hearing decision without holding an oral hearing. However, the notice of the decision will inform you that you have the right to an oral hearing and that you have a right to examine the evidence on which the decision is based.

(b) *Parties do not wish to appear.* (1) The administrative law judge may decide a case on the record and not conduct an oral hearing if—

(i) You and all the parties indicate in writing that you do not wish to appear before the administrative law judge at an oral hearing; or

(ii) You live outside the United States and you do not inform us that you want to appear and there are no other parties who wish to appear.

(2) When an oral hearing is not held, the administrative law judge shall make a record of the material evidence. The record will include the applications, written statements, certificates, reports, affidavits, and other documents that were used in making the determination under review and any additional evidence you or any other party to the hearing present in writing. The decision of the administrative law judge must be based on this record.

(c) *Case remanded for a revised determination.* (1) The administrative law judge may remand a case to the appropriate component of our office for a revised determination if there is reason to believe that the revised determination would be fully favorable to you. This could happen if the administrative law judge receives new and material evidence or if there is a change in the law that permits the favorable determination.

(2) Unless you request the remand, the administrative law judge shall notify you that your case has been remanded and tell you that if you object, you must notify him or her of your objections within 10 days of the date the case is remanded or we will assume that you agree to the remand. If you object to the remand, the administrative law judge will consider the objection and rule on it in writing.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.949 Presenting written statements and oral arguments.

You or a person you designate to act as your representative may appear before the administrative law judge to state your case, to present a written summary of your case, or to enter written statements about the facts and law material to your case in the record. A copy of your written statements should be filed for each party.

§ 404.950 Presenting evidence at a hearing before an administrative law judge.

(a) *The right to appear and present evidence.* Any party to a hearing has the right to appear before the administrative law judge, either personally or by means of a designated representative, to present evidence and to state his or her position.

(b) *Waiver of the right to appear.* You may send the administrative law judge a waiver or a written statement indicating that you do not wish to appear at the hearing. You may withdraw this waiver any time before a notice of the hearing decision is mailed to you. Even if all of the parties waive their right to appear at a hearing, the administrative law judge may notify them of a time and a place for an oral hearing, if he or she believes that a personal appearance

and testimony by you or any other party is necessary to decide the case.

(c) *What evidence is admissible at a hearing.* The administrative law judge may receive evidence at the hearing even though the evidence would not be admissible in court under the rules of evidence used by the court.

(d) *Subpoenas.* (1) When it is reasonably necessary for the full presentation of a case, an administrative law judge or a member of the Appeals Council may, on his or her own initiative or at the request of a party, issue subpoenas for the appearance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents that are material to an issue at the hearing.

(2) Parties to a hearing who wish to subpoena documents or witnesses must file a written request for the issuance of a subpoena with the administrative law judge or at one of our offices at least 5 days before the hearing date. The written request must give the names of the witnesses or documents to be produced; describe the address or location of the witnesses or documents with sufficient detail to find them; state the important facts that the witness or document is expected to prove; and indicate why these facts could not be proven without issuing a subpoena.

(3) We will pay the cost of issuing the subpoena.

(4) We will pay subpoenaed witnesses the same fees and mileage they would receive if they had been subpoenaed by a Federal district court.

(e) *Witnesses at a hearing.* Witnesses may appear at a hearing. They shall testify under oath or affirmation, unless the administrative law judge finds an important reason to excuse them from taking an oath or affirmation. The administrative law judge may ask the witnesses any questions material to the issues and shall allow the parties or their designated representatives to do so.

(f) *Collateral estoppel—issues previously decided.* An issue at your hearing may be a fact that has already been decided in one of our previous determinations or decisions in a claim involving the same parties, but arising under a different title of the Act or under the Federal Coal Mine Health and Safety Act. If this happens, the administrative law judge will not consider the issue again, but will accept the factual finding made in the previous determination or decision unless there are reasons to believe that it was wrong.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.951 When a record of a hearing before an administrative law judge is made.

The administrative law judge shall make a complete record of the hearing proceedings. The record will be prepared as a typed copy of the proceedings if—

(a) The case is sent to the Appeals Council without a decision or with a recommended decision by the administrative law judge;

(b) You seek judicial review of your case by filing an action in a Federal district court within the stated time period, unless we request the court to remand the case; or

(c) An administrative law judge or the Appeals Council asks for a written record of the proceedings.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.952 Consolidated hearing before an administrative law judge.

(a) *General.* (1) A consolidated hearing may be held if—

(i) You have requested a hearing to decide your benefit rights under title II of the Act and you have also requested a hearing to decide your rights under another law we administer; and

(ii) One or more of the issues to be considered at the hearing you requested are the same issues that are involved in another claim you have pending before us.

(2) If the administrative law judge decides to hold the hearing on both claims, he or she decides both claims, even if we have not yet made an initial or reconsidered determination on the other claim.

(b) *Record, evidence, and decision.* There will be a single record at a consolidated hearing. This means that the

evidence introduced in one case becomes evidence in the other(s). The administrative law judge may make either a separate or consolidated decision.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.953 The decision of an administrative law judge.

(a) *General.* The administrative law judge shall issue a written decision that gives the findings of fact and the reasons for the decision. The decision must be based on evidence offered at the hearing or otherwise included in the record. The administrative law judge shall mail a copy of the decision to all the parties at their last known address. The Appeals Council may also receive a copy of the decision.

(b) *Recommended decision.* Although an administrative law judge will usually make a decision, he or she may send the case to the Appeals Council with a recommended decision where appropriate. The administrative law judge will mail a copy of the recommended decision to the parties at their last known addresses and send the recommended decision to the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989]

§ 404.955 The effect of an administrative law judge's decision.

The decision of the administrative law judge is binding on all parties to the hearing unless—

(a) You or another party request a review of the decision by the Appeals Council within the stated time period, and the Appeals Council reviews your case;

(b) You or another party requests a review of the decision by the Appeals Council within the stated time period, the Appeals Council denies your request for review, and you seek judicial review of your case by filing an action in a Federal district court;

(c) The decision is revised by an administrative law judge or the Appeals Council under the procedures explained in § 404.987;

(d) The expedited appeals process is used;

(e) The decision is a recommended decision directed to the Appeals Council; or

(f) In a case remanded by a Federal court, the Appeals Council assumes jurisdiction under the procedures in § 404.984.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986; 54 FR 37792, Sept. 13, 1989]

§ 404.956 Removal of a hearing request from an administrative law judge to the Appeals Council.

If you have requested a hearing and the request is pending before an administrative law judge, the Appeals Council may assume responsibility for holding a hearing by requesting that the administrative law judge send the hearing request to it. If the Appeals Council holds a hearing, it shall conduct the hearing according to the rules for hearings before an administrative law judge. Notice shall be mailed to all parties at their last known address telling them that the Appeals Council has assumed responsibility for the case.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.957 Dismissal of a request for a hearing before an administrative law judge.

An administrative law judge may dismiss a request for a hearing under any of the following conditions:

(a) At any time before notice of the hearing decision is mailed, you or the party or parties that requested the hearing ask to withdraw the request. This request may be submitted in writing to the administrative law judge or made orally at the hearing.

(b)(1)(i) Neither you nor the person you designate to act as your representative appears at the time and place set for the hearing and you have been notified before the time set for the hearing that your request for hearing may be dismissed without further notice if you did not appear at the time and place of hearing, and good cause has not been found by the administrative law judge for your failure to appear; or

(ii) Neither you nor the person you designate to act as your representative appears at the time and place set for

the hearing and within 10 days after the administrative law judge mails you a notice asking why you did not appear, you do not give a good reason for the failure to appear.

(2) In determining good cause or good reason under this paragraph, we will consider any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have.

(c) The administrative law judge decides that there is cause to dismiss a hearing request entirely or to refuse to consider any one or more of the issues because—

(1) The doctrine of *res judicata* applies in that we have made a previous determination or decision under this subpart about your rights on the same facts and on the same issue or issues, and this previous determination or decision has become final by either administrative or judicial action;

(2) The person requesting a hearing has no right to it under § 404.930;

(3) You did not request a hearing within the stated time period and we have not extended the time for requesting a hearing under § 404.933(c); or

(4) You die, there are no other parties, and we have no information to show that another person may be adversely affected by the determination that was to be reviewed at the hearing. However, dismissal of the hearing request will be vacated if, within 60 days after the date of the dismissal, another person submits a written request for a hearing on the claim and shows that he or she may be adversely affected by the determination that was to be reviewed at the hearing.

[45 FR 52081, Aug. 5, 1980, as amended at 50 FR 21438, May 24, 1985; 51 FR 303, Jan. 3, 1986; 59 FR 1634, Jan. 12, 1994]

§ 404.958 Notice of dismissal of a request for a hearing before an administrative law judge.

We shall mail a written notice of the dismissal of the hearing request to all parties at their last known address. The notice will state that there is a right to request that the Appeals Council vacate the dismissal action.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.959 Effect of dismissal of a request for a hearing before an administrative law judge.

The dismissal of a request for a hearing is binding, unless it is vacated by an administrative law judge or the Appeals Council.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.960 Vacating a dismissal of a request for a hearing before an administrative law judge.

An administrative law judge or the Appeals Council may vacate any dismissal of a hearing request if, within 60 days after the date you receive the dismissal notice, you request that the dismissal be vacated and show good cause why the hearing request should not have been dismissed. The Appeals Council itself may decide within 60 days after the notice of dismissal is mailed to vacate the dismissal. The Appeals Council shall advise you in writing of any action it takes.

[45 FR 52081, Aug. 5, 1980, as amended at 51 FR 303, Jan. 3, 1986]

§ 404.961 Prehearing and posthearing conferences.

The administrative law judge may decide on his or her own, or at the request of any party to the hearing, to hold a prehearing or posthearing conference to facilitate the hearing or the hearing decision. The administrative law judge shall tell the parties of the time, place and purpose of the conference at least seven days before the conference date, unless the parties have indicated in writing that they do not wish to receive a written notice of the conference. At the conference, the administrative law judge may consider matters in addition to those stated in the notice, if the parties consent in writing. A record of the conference will be made. The administrative law judge shall issue an order stating all agreements and actions resulting from the conference. If the parties do not object, the agreements and actions become part of the hearing record and are binding on all parties.

§ 404.965 [Reserved]

APPEALS COUNCIL REVIEW

§ 404.966 Testing elimination of the request for Appeals Council review.

(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 elimination of the request for review by the Appeals Council. These procedures will apply in randomly selected cases in which we have tested a combination of model procedures for modifying the disability claim process as authorized under §§ 404.906 and 404.943, and in which an administrative law judge has issued a decision (not including a recommended decision) that is less than wholly favorable to you.

(b) *Effect of an administrative law judge's decision.* In a case to which the procedures of this section apply, the decision of an administrative law judge will be binding on all the parties to the hearing unless —

(1) You or another party file an action concerning the decision in Federal district court;

(2) The Appeals Council decides to review the decision on its own motion under the authority provided in § 404.969, and it issues a notice announcing its decision to review the case on its own motion no later than the day before the filing date of a civil action establishing the jurisdiction of a Federal district court; or

(3) The decision is revised by the administrative law judge or the Appeals Council under the procedures explained in § 404.987.

(c) *Notice of the decision of an administrative law judge.* The notice of decision the administrative law judge issues in a case processed under this section will advise you and any other parties to the decision that you may file an action in a Federal district court within 60 days after the date you receive notice of the decision.

(d) *Extension of time to file action in Federal district court.* Any party having a right to file a civil action under this section may request that the time for filing an action in 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. 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 will use the standards in § 404.911.

[62 FR 49602, Sept. 23, 1997]

§ 404.967 Appeals Council review—general.

If you or any other party is dissatisfied with the hearing decision or with the dismissal of a hearing request, you may request that the Appeals Council review that action. The Appeals Council may deny or dismiss the request for review, or it may grant the request and either issue a decision or remand the case to an administrative law judge. The Appeals Council shall notify the parties at their last known address of the action it takes.

§ 404.968 How to request Appeals Council review.

(a) *Time and place to request Appeals Council review.* You may request Appeals Council review by filing a written request. Any documents or other evidence you wish to have considered by the Appeals Council should be submitted with your request for review. You may file your request—

(1) Within 60 days after the date you receive notice of the hearing decision or dismissal (or within the extended time period if we extend the time as provided in paragraph (b) of this section);

(2) At one of our offices, the Veterans Administration Regional Office in the Philippines, or an office of the Railroad Retirement Board if you have 10 or more years of service in the railroad industry.

(b) *Extension of time to request review.* You or any party to a hearing decision may ask that the time for filing a request for the review be extended. The request for an extension of time must be in writing. It must be filed with the Appeals Council, and it must give the reasons why the request for review was not filed within the stated time period. If you show that you had good cause

for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

§ 404.969 Appeals Council initiates review.

(a) *General.* Anytime within 60 days after the date of a decision or dismissal that is subject to review under this section, the Appeals Council may decide on its own motion to review the action that was taken in your case. We may refer your case to the Appeals Council for it to consider reviewing under this authority.

(b) *Identification of cases.* We will identify a case for referral to the Appeals Council for possible review under its own-motion authority before we effectuate a decision in the case. We will identify cases for referral to the Appeals Council through random and selective sampling techniques, which we may use in association with examination of the cases identified by sampling. We will also identify cases for referral to the Appeals Council through the evaluation of cases we conduct in order to effectuate decisions.

(1) *Random and selective sampling and case examinations.* We may use random and selective sampling to identify cases involving any type of action (i.e., wholly or partially favorable decisions, unfavorable decisions, or dismissals) and any type of benefits (i.e., benefits based on disability and benefits not based on disability). We will use selective sampling to identify cases that exhibit problematic issues or fact patterns that increase the likelihood of error. Neither our random sampling procedures nor our selective sampling procedures will identify cases based on the identity of the decisionmaker or the identity of the office issuing the decision. We may examine cases that have been identified through random or selective sampling to refine the identification of cases that may meet the criteria for review by the Appeals Council.

(2) *Identification as a result of the effectuation process.* We may refer a case requiring effectuation to the Appeals Council if, in the view of the effectuating component, the decision cannot be effectuated because it contains a clerical error affecting the outcome of the claim; the decision is clearly inconsistent with the Social Security Act, the regulations, or a published ruling; or the decision is unclear regarding a matter that affects the claim's outcome.

(c) *Referral of cases.* We will make referrals that occur as the result of a case examination or the effectuation process in writing. The written referral based on the results of such a case examination or the effectuation process will state the referring component's reasons for believing that the Appeals Council should review the case on its own motion. Referrals that result from selective sampling without a case examination may be accompanied by a written statement identifying the issue(s) or fact pattern that caused the referral. Referrals that result from random sampling without a case examination will only identify the case as a random sample case.

(d) *Appeals Council's action.* If the Appeals Council decides to review a decision or dismissal on its own motion, it will mail a notice of review to all the parties as provided in § 404.973. The Appeals Council will include with that notice a copy of any written referral it has received under paragraph (c) of this section. The Appeals Council's decision to review a case is established by its issuance of the notice of review. If it is unable to decide within the applicable 60-day period whether to review a decision or dismissal, the Appeals Council may consider the case to determine if the decision or dismissal should be reopened pursuant to §§ 404.987 and 404.988. If the Appeals Council decides to review a decision on its own motion or to reopen a decision as provided in §§ 404.987 and 404.988, the notice of review or the notice of reopening issued by the Appeals Council will advise, where appropriate, that interim benefits will be payable if a final decision has not been issued within 110 days after the date of the decision that is reviewed or reopened, and that any interim benefits paid will not be considered overpayments unless the benefits are fraudulently obtained.

[63 FR 36570, July 7, 1998]

§ 404.970 Cases the Appeals Council will review.

(a) The Appeals Council will review a case if—

(1) There appears to be an abuse of discretion by the administrative law judge;

(2) There is an error of law;

(3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence; or

(4) There is a broad policy or procedural issue that may affect the general public interest.

(b) If new and material evidence is submitted, the Appeals Council shall consider the additional evidence only where it relates to the period on or before the date of the administrative law judge hearing decision. The Appeals Council shall evaluate the entire record including the new and material evidence submitted if it relates to the period on or before the date of the administrative law judge hearing decision. It will then review the case if it finds that the administrative law judge's action, findings, or conclusion is contrary to the weight of the evidence currently of record.

[45 FR 52081, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§ 404.971 Dismissal by Appeals Council.

The Appeals Council will dismiss your request for review if you did not file your request within the stated period of time and the time for filing has not been extended. The Appeals Council may also dismiss any proceedings before it if—

(a) You and any other party to the proceedings files a written request for dismissal; or

(b) You or any other party to the proceedings dies and the record clearly shows that dismissal will not adversely affect any other person who wishes to continue the action.

§ 404.972 Effect of dismissal of request for Appeals Council review.

The dismissal of a request for Appeals Council review is binding and not subject to further review.

§ 404.973 Notice of Appeals Council review.

When the Appeals Council decides to review a case, it shall mail a notice to all parties at their last known address stating the reasons for the review and the issues to be considered.

§ 404.974 Obtaining evidence from Appeals Council.

You may request and receive copies or a statement of the documents or other written evidence upon which the hearing decision or dismissal was based and a copy or summary of the transcript of oral evidence. However, you will be asked to pay the costs of providing these copies unless there is a good reason why you should not pay.

§ 404.975 Filing briefs with the Appeals Council.

Upon request, the Appeals Council shall give you and all other parties a reasonable opportunity to file briefs or other written statements about the facts and law relevant to the case. A copy of each brief or statement should be filed for each party.

§ 404.976 Procedures before Appeals Council on review.

(a) *Limitation of issues.* The Appeals Council may limit the issues it considers if it notifies you and the other parties of the issues it will review.

(b) *Evidence.* (1) The Appeals Council will consider all the evidence in the administrative law judge hearing record as well as any new and material evidence submitted to it which relates to the period on or before the date of the administrative law judge hearing decision. If you submit evidence which does not relate to the period on or before the date of the administrative law judge hearing decision, the Appeals Council will return the additional evidence to you with an explanation as to why it did not accept the additional evidence and will advise you of your right to file a new application. The notice returning the evidence to you will also advise you that if you file a new application within 6 months after the date of the Appeals Council's notice, your request for review will constitute a written statement indicating an intent to claim benefits in accordance

with § 404.630. If a new application is filed within 6 months of this notice, the date of the request for review will be used as the filing date for your application.

(2) If additional evidence is needed, the Appeals Council may remand the case to an administrative law judge to receive evidence and issue a new decision. However, if the Appeals Council decides that it can obtain the evidence more quickly, it may do so, unless it will adversely affect your rights.

(c) *Oral argument.* You may request to appear before the Appeals Council to present oral argument. The Appeals Council will grant your request if it decides that your case raises an important question of law or policy or that oral argument would help to reach a proper decision. If your request to appear is granted, the Appeals Council will tell you the time and place of the oral argument at least 10 days before the scheduled date.

[45 FR 52081, Aug. 5, 1980, as amended at 52 FR 4004, Feb. 9, 1987]

§ 404.977 Case remanded by Appeals Council.

(a) *When the Appeals Council may remand a case.* The Appeals Council may remand a case to an administrative law judge so that he or she may hold a hearing and issue a decision or a recommended decision. The Appeals Council may also remand a case in which additional evidence is needed or additional action by the administrative law judge is required.

(b) *Action by administrative law judge on remand.* The administrative law judge shall take any action that is ordered by the Appeals Council and may take any additional action that is not inconsistent with the Appeals Council's remand order.

(c) *Notice when case is returned with a recommended decision.* When the administrative law judge sends a case to the Appeals Council with a recommended decision, a notice is mailed to the parties at their last known address. The notice tells them that the case has been sent to the Appeals Council, explains the rules for filing briefs or other written statements with the Appeals Council, and includes a copy of the recommended decision.

(d) *Filing briefs with and obtaining evidence from the Appeals Council.* (1) You may file briefs or other written statements about the facts and law relevant to your case with the Appeals Council within 20 days of the date that the recommended decision is mailed to you. Any party may ask the Appeals Council for additional time to file briefs or statements. The Appeals Council will extend this period, as appropriate, if you show that you had good cause for missing the deadline.

(2) All other rules for filing briefs with and obtaining evidence from the Appeals Council follow the procedures explained in this subpart.

(e) *Procedures before the Appeals Council.* (1) The Appeals Council, after receiving a recommended decision, will conduct its proceedings and issue its decision according to the procedures explain in this subpart.

(2) If the Appeals Council believes that more evidence is required, it may again remand the case to an administrative law judge for further inquiry into the issues, rehearing, receipt of evidence, and another decision or recommended decision. However, if the Appeals Council decides that it can get the additional evidence more quickly, it will take appropriate action.

§ 404.979 Decision of Appeals Council.

After it has reviewed all the evidence in the administrative law judge hearing record and any additional evidence received, subject to the limitations on Appeals Council consideration of additional evidence in §§ 404.970(b) and 404.976(b), the Appeals Council will make a decision or remand the case to an administrative law judge. The Appeals Council may affirm, modify or reverse the administrative law judge hearing decision or it may adopt, modify or reject a recommended decision. A copy of the Appeals Council's decision will be mailed to the parties at their last known address.

[52 FR 4004, Feb. 9, 1987]

§ 404.981 Effect of Appeals Council's decision or denial of review.

The Appeals Council may deny a party's request for review or it may decide to review a case and make a decision. The Appeals Council's decision, or the

decision of the administrative law judge if the request for review is denied, is binding unless you or another party file an action in Federal district court, or the decision is revised. You may file an action in a Federal district court within 60 days after the date you receive notice of the Appeals Council's action.

§ 404.982 Extension of time to file action in Federal district court.

Any party to the Appeals Council's decision or denial of review, or to an expedited appeals process agreement, may request that the time for filing an action in a Federal district court be extended. The request must be in writing and it must give the reasons why the action was not filed within the stated time period. The request must be filed with the Appeals Council, or if it concerns an expedited appeals process agreement, with one of our offices. If you show that you had good cause for missing the deadline, the time period will be extended. To determine whether good cause exists, we use the standards explained in § 404.911.

COURT REMAND CASES

§ 404.983 Case remanded by a Federal court.

When a Federal court remands a case to the Commissioner for further consideration, the Appeals Council, acting on behalf of the Commissioner, may make a decision, or it may remand the case to an administrative law judge with instructions to take action and issue a decision or return the case to the Appeals Council with a recommended decision. If the case is remanded by the Appeals Council, the procedures explained in § 404.977 will be followed. Any issues relating to your claim may be considered by the administrative law judge whether or not they were raised in the administrative proceedings leading to the final decision in your case.

[54 FR 37792, Sept. 13, 1989, as amended at 62 FR 38450, July 18, 1997]

§ 404.984 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.

(a) *General.* In accordance with § 404.983, when a case is remanded by a Federal court for further consideration, the decision of the administrative law judge will become the final decision of the Commissioner 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 Commissioner 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 Commissioner 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 Commissioner 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 Commissioner 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 Commissioner after remand.

[54 FR 37792, Sept. 13, 1989; 54 FR 40779, Oct. 3, 1989; 62 FR 38450, July 18, 1997]

§ 404.985 Application of circuit court law.

The procedures which follow apply to administrative determinations or decisions on claims involving the application of circuit court law.

(a) *General.* We will apply a holding in a United States Court of Appeals decision that we determine conflicts with our interpretation of a provision of the Social Security Act or regulations unless the Government seeks further judicial 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 the administrative review process within the applicable circuit unless the holding, by its nature, applies only at certain levels of adjudication.

(b) *Issuance of an Acquiescence Ruling.* 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 judicial review or is unsuccessful on further review, we will issue a Social Security Acquiescence Ruling. The Acquiescence Ruling will describe the administrative case and the court decision, identify the issue(s) involved, and explain how we will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These Acquiescence Rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations and decisions made on or after that date unless an Acquiescence Ruling is rescinded as stated in paragraph (e) of this section. The process we will use

when issuing an Acquiescence Ruling follows:

(1) We will release an Acquiescence Ruling for publication in the FEDERAL REGISTER for any precedential circuit court decision that we determine contains a holding that conflicts with our interpretation of a provision of the Social Security Act or regulations no later than 120 days from the receipt of the court's decision. This timeframe will not apply when we decide to seek further judicial review of the circuit court decision or when coordination with the Department of Justice and/or other Federal agencies makes this timeframe no longer feasible.

(2) If we make a determination or decision on your claim between the date of a circuit court decision and the date we publish an Acquiescence Ruling, you may request application of the published Acquiescence Ruling to the prior determination or decision. You must demonstrate that application of the Acquiescence Ruling could change the prior determination or decision in your case. You may demonstrate this by submitting a statement that cites the Acquiescence Ruling or the holding or portion of a circuit court decision which could change the prior determination or decision in your case. If you can so demonstrate, we will readjudicate the claim in accordance with the Acquiescence Ruling at the level at which it was last adjudicated. Any readjudication will be limited to consideration of the issue(s) covered by the Acquiescence 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 you file a request for readjudication within the 60-day appeal period and we deny that request, we shall extend the time to file an appeal on the merits of the claim to 60 days after the date that we deny the request for readjudication.

(3) After we receive a precedential circuit court decision and determine that an Acquiescence Ruling may be required, we will begin to identify those claims that are pending before us within the circuit and that might be subject to readjudication if an Acquiescence Ruling is subsequently issued. When an Acquiescence Ruling is published, we will send a notice to those individuals whose cases we have identified which may be affected by the Acquiescence Ruling. The notice will provide information about the Acquiescence Ruling and the right to request readjudication under that Acquiescence Ruling, as described in paragraph (b)(2) of this section. It is not necessary for an individual to receive a notice in order to request application of an Acquiescence Ruling to his or her claim, as described in paragraph (b)(2) of this section.

(c) *Relitigation of court's holding after publication of an Acquiescence Ruling.* After we have published an 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 may 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 circuit court decision 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 an Acquiescence Ruling.

(2) The General Counsel of the Social Security Administration, 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 to selected claims in the administrative review process 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 within the circuit to claims in the administrative review process selected for relitigation. The notice will explain why we made this decision.

(d) *Notice of relitigation.* 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) *Rescission of an Acquiescence Ruling.* We will rescind as obsolete an Acquiescence Ruling and apply our interpretation of the Social Security Act or regulations by publishing a notice in the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) We subsequently clarify, modify or revoke the regulation or ruling that was the subject of a 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.

[63 FR 24932, May 6, 1998]

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

§ 404.987 Reopening and revising determinations and decisions.

(a) *General.* Generally, if you are dissatisfied with a determinationor decision made in the administrative review process, but do not request further review within the stated time period, you lose your right to further review and that determination or decision becomes final. However, a determination or a decision made in your case which is otherwise final and binding may be reopened and revised by us.

(b) *Procedure for reopening and revision.* We may reopen a final determination or decision on our own initiative, or you may ask that a final determination or a decision to which you were a party be reopened. In either instance, if we reopen the determination or decision, we may revise that determination or decision. The conditions under which we may reopen a previous determination or decision, either on our own initiative or at your request, are explained in § 404.988.

[59 FR 8535, Feb. 23, 1994]

§ 404.988 Conditions for reopening.

A determination, revised determination, decision, or revised decision may be reopened—

(a) Within 12 months of the date of the notice of the initial determination, for any reason;

(b) Within four years of the date of the notice of the initial determination if we find good cause, as defined in § 404.989, to reopen the case; or

(c) At any time if—

(1) It was obtained by fraud or similar fault (see § 416.1488(c) of this chapter

for factors which we take into account in determining fraud or similar fault);

(2) Another person files a claim on the same earnings record and allowance of the claim adversely affects your claim;

(3) A person previously determined to be dead, and on whose earnings record your entitlement is based, is later found to be alive;

(4) Your claim was denied because you did not prove that a person died, and the death is later established—

(i) By a presumption of death under § 404.721(b); or

(ii) By location or identification of his or her body;

(5) The Railroad Retirement Board has awarded duplicate benefits on the same earnings record;

(6) It either—

(i) Denies the person on whose earnings record your claim is based gratuitous wage credits for military or naval service because another Federal agency (other than the Veterans Administration) has erroneously certified that it has awarded benefits based on the service; or

(ii) Credits the earnings record of the person on which your claim is based with gratuitous wage credits and another Federal agency (other than the Veterans Administration) certifies that it has awarded a benefit based on the period of service for which the wage credits were granted;

(7) It finds that the claimant did not have insured status, but earnings were later credited to his or her earnings record to correct errors apparent on the face of the earnings record (section 205(c)(5)(C) of the Act), to enter items transferred by the Railroad Retirement Board, which were credited under the Railroad Retirement Act when they should have been credited to the claimant's Social Security earnings record (section 205(c)(5)(D) of the Act), or to correct errors made in the allocation of wages or self-employment income to individuals or periods (section 205(c)(5)(G) of the Act), which would have given him or her insured status at the time of the determination or decision if the earnings had been credited to his or her earnings record at that time, and the evidence of these earnings was in our possession or the possession of the Railroad Retirement Board at the time of the determination or decision;

(8) It is wholly or partially unfavorable to a party, but only to correct clerical error or an error that appears on the face of the evidence that was considered when the determination or decision was made;

(9) It finds that you are entitled to monthly benefits or to a lump sum death payment based on the earnings of a deceased person, and it is later established that:

(i) You were convicted of a felony or an act in the nature of a felony for intentionally causing that person's death; or

(ii) If you were subject to the juvenile justice system, you were found by a court of competent jurisdiction to have intentionally caused that person's death by committing an act which, if committed by an adult, would have been considered a felony or an act in the nature of a felony;

(10) It either—

(i) Denies the person on whose earnings record your claim is based deemed wages for internment during World War II because of an erroneous finding that a benefit based upon the internment has been determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(ii) Awards the person on whose earnings record your claim is based deemed wages for internment during World War II and a benefit based upon the internment is determined by an agency of the United States to be payable under another Federal law or under a system established by that agency; or

(11) It is incorrect because—

(i) You were convicted of a crime that affected your right to receive benefits or your entitlement to a period of disability; or

(ii) Your conviction of a crime that affected your right to receive benefits or your entitlement to a period of disability is overturned.

[45 FR 52081, Aug. 5, 1980, as amended at 49 FR 46369, Nov. 26, 1984; 51 FR 18313, May 19, 1986; 59 FR 1635, Jan. 12, 1994; 60 FR 19165, Apr. 17, 1995]

§ 404.989 Good cause for reopening.

(a) We will find that there is good cause to reopen a determination or decision if—

(1) New and material evidence is furnished;

(2) A clerical error in the computation or recomputation of benefits was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or adminstrative ruling upon which the determination or decision was made.

§ 404.990 Finality of determinations and decisions on revision of an earnings record.

A determination or a decision on a revision of an earnings record may be reopened only within the time period and under the conditions provided in section 205(c) (4) or (5) of the Act, or within 60 days after the date you receive notice of the determination or decision, whichever is later.

§ 404.991 Finality of determinations and decisions to suspend benefit payments for entire taxable year because of earnings.

A determination or decision to suspend benefit payments for an entire taxable year because of earnings may be reopened only within the time period and under the conditions provided in section 203(h)(1)(B) of the Act.

§ 404.991a Late completion of timely investigation.

We may revise a determination or decision after the applicable time period in § 404.988(a) or § 404.988(b) expires if we begin an investigation into whether to revise the determination or decision before the applicable time period expires. We may begin the investigation either based on a request by you or by an action on our part. The investigation is a process of gathering facts after a determination or decision has been reopened to determine if a revision of the determination or decision is applicable.

(a) If we have diligently pursued the investigation to its conclusion, we may revise the determination or decision. The revision may be favorable or unfavorable to you. ''Diligently pursued'' means that in light of the facts and circumstances of a particular case, the necessary action was undertaken and carried out as promptly as the circumstances permitted. Diligent pursuit will be presumed to have been met if we conclude the investigation and if necessary, revise the determination or decision within 6 months from the date we began the investigation.

(b) If we have not diligently pursued the investigation to its conclusion, we will revise the determination or decision if a revision is applicable and if it will be favorable to you. We will not revise the determination or decision if it will be unfavorable to you.

[49 FR 46369, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984]

§ 404.992 Notice of revised determination or decision.

(a) When a determination or decision is revised, notice of the revision will be mailed to the parties at their last known address. The notice will state the basis for the revised determination or decision and the effect of the revision. The notice will also inform the parties of the right to further review.

(b) If a reconsidered determination that you are disabled, based on medical factors, is reopened for the purpose of being revised, you will be notified, in writing, of the proposed revision and of your right to request that a disability hearing be held before a revised reconsidered determination is issued. If a revised reconsidered determination is issued, you may request a hearing before an administrative law judge.

(c) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based on evidence not included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action and of your right to request that a hearing be held before any further action is taken. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the

Appeals Council, or the Appeals Council may review the decision on its own initiative.

(d) If an administrative law judge or the Appeals Council proposes to revise a decision, and the revision would be based only on evidence included in the record on which the prior decision was based, you and any other parties to the decision will be notified, in writing, of the proposed action. If a revised decision is issued by an administrative law judge, you and any other party may request that it be reviewed by the Appeals Council, or the Appeals Council may review the decision on its own initiative.

[51 FR 303, Jan. 3, 1986]

§404.993 Effect of revised determination or decision.

A revised determination or decision is binding unless—

(a) You or another party to the revised determination file a written request for reconsideration or a hearing before an administrative law judge, as appropriate;

(b) You or another party to the revised decision file, as appropriate, a request for review by the Appeals Council or a hearing before an administrative law judge;

(c) The Appeals Council reviews the revised decision; or

(d) The revised determination or decision is further revised.

[51 FR 303, Jan. 3, 1986]

§404.994 Time and place to request a hearing on revised determination or decision.

You or another party to a revised determination or decision may request, as approporiate, further review or a hearing on the revision by filing a request in writing at one of our offices within 60 days after the date you receive notice of the revision. Further review or a hearing will be held on the revision according to the rules of this subpart.

§404.995 Finality of findings when later claim is filed on same earnings record.

If two claims for benefits are filed on the same earnings records, findings of fact made in a determination on the first claim may be revised in determining or deciding the second claim, even though the time limit for revising the findings made in the first claim has passed. However, a finding in connection with a claim that a person was fully or currently insured at the time of filing an application, at the time of death, or any other pertinent time, may be revised only under the conditions stated in §404.988.

§404.996 Increase in future benefits where time period for reopening expires.

If, after the time period for reopening under §404.988(b) has ended, new evidence is furnished showing a different date of birth or additional earnings for you (or for the person on whose earnings record your claim was based) which would otherwise increase the amount of your benefits, we will make the increase (subject to the limitations provided in section 205(c) (4) and (5) of the Act) but only for benefits payable after the time we received the new evidence. (If the new evidence we receive would lead to a decrease in your benefits, we will take no action if we cannot reopen under §404.988.)

[49 FR 46369, Nov. 26, 1984]

PAYMENT OF CERTAIN TRAVEL EXPENSES

§404.999a Payment of certain travel expenses—general.

When you file a claim for Social Security benefits, you may incur certain travel expenses in pursuing your claim. Sections 404.999b–404.999d explain who may be reimbursed for travel expenses, the types of travel expenses that are reimbursable, and when and how to claim reimbursement. Generally, the agency that requests you to travel will be the agency that reimburses you. No later than when it notifies you of the examination or hearing described in §404.999b(a), that agency will give you information about the right to travel reimbursement, the right to advance payment and how to request it, the rules on means of travel and unusual travel costs, and the need to submit receipts.

[51 FR 8808, Mar. 14, 1986]

§ 404.999b Who may be reimbursed.

(a) The following individuals may be reimbursed for certain travel expenses—

(1) You, when you attend medical examinations upon request in connection with disability determinations; these are medical examinations requested by the State agency or by us when additional medical evidence is necessary to make a disability determination (also referred to as consultative examinations, see § 404.1517);

(2) You, your representative (see § 404.1705 (a) and (b)), and all unsubpoenaed witnesses we or the State agency determines to be reasonably necessary who attend disability hearings; and

(3) You, your representative, and all unsubpoenaed witnesses we determine to be reasonably necessary who attend hearings on any claim for benefits before an administrative law judge.

(b) Sections 404.999a through 404.999d do not apply to subpoenaed witnesses. They are reimbursed under §§ 404.950(d) and 404.916(b)(1).

[51 FR 8808, Mar. 14, 1986]

§ 404.999c What travel expenses are reimbursable.

Reimbursable travel expenses include the ordinary expenses of public or private transportation as well as unusual costs due to special circumstances.

(a) Reimbursement for ordinary travel expenses is limited—

(1) To the cost of travel by the most economical and expeditious means of transportation available and appropriate to the individual's condition of health as determined by the State agency or by us, considering the available means in the following order—

(i) Common carrier (air, rail, or bus);

(ii) Privately owned vehicles;

(iii) Commercially rented vehicles and other special conveyances;

(2) If air travel is necessary, to the coach fare for air travel between the specified travel points involved unless first-class air travel is authorized in advance by the State agency or by the Secretary in instances when—

(i) Space is not available in less-than-first-class accommodations on any scheduled flights in time to accomplish the purpose of the travel;

(ii) First-class accommodations are necessary because you, your representative, or reasonably necessary witness is so handicapped or otherwise impaired that other accommodations are not practical and the impairment is substantiated by competent medical authority;

(iii) Less-than-first-class accommodations on foreign carriers do not provide adequate sanitation or health standards; or

(iv) The use of first-class accommodations would result in an overall savings to the government based on economic considerations, such as the avoidance of additional subsistence costs that would be incurred while awaiting availability of less-than-first-class accommodations.

(b) Unusual travel costs may be reimbursed but must be authorized in advance and in writing by us or the appropriate State official, as applicable, unless they are unexpected or unavoidable; we or the State agency must determine their reasonableness and necessity and must approve them before payment can be made. Unusual expenses that may be covered in connection with travel include, but are not limited to—

(1) Ambulance services;

(2) Attendant services;

(3) Meals;

(4) Lodging; and

(5) Taxicabs.

(c) If we reimburse you for travel, we apply the rules in §§ 404.999b through 404.999d and the same rates and conditions of payment that govern travel expenses for Federal employees as authorized under 41 CFR chapter 301. If a State agency reimburses you, the reimbursement rates shall be determined by the rules in §§ 404.999b through 404.999d and that agency's rules and regulations and may differ from one agency to another and also may differ from the Federal reimbursement rates.

(1) When public transportation is used, reimbursement will be made for the actual costs incurred, subject to the restrictions in paragraph (a)(2) of this section on reimbursement for first-class air travel.

(2) When travel is by a privately owned vehicle, reimbursement will be made at the current Federal or State

mileage rate specified for that geographic location plus the actual costs of tolls and parking, if travel by a privately owned vehicle is determined appropriate under paragraph (a)(1) of this section. Otherwise, the amount of reimbursement for travel by privately owned vehicle cannot exceed the total cost of the most economical public transportation available for travel between the same two points. *Total cost* includes the cost for all the authorized travelers who travel in the same privately owned vehicle. Advance approval of travel by privately owned vehicle is not required (but could give you assurance of its approval).

(3) Sometimes your health condition dictates a mode of transportation different from the most economical and expeditious. In order for your health to require a mode of transportation other than common carrier or passenger car, you must be so handicapped or otherwise impaired as to require special transportation arrangements and the conditions must be substantiated by competent medical authority.

(d) For travel to a hearing—

(1) Reimbursement is limited to travel within the U.S. For this purpose, the U.S. includes the U.S. as defined in §404.2(c)(6) and the Northern Mariana Islands.

(2) We or the State agency will reimburse you, your representative, or an unsubpoenaed witness only if the distance from the person's residence or office (whichever he or she travels from) to the hearing site exceeds 75 miles.

(3) For travel expenses incurred on or after April 1, 1991, the amount of reimbursement under this section for travel by your representative to attend a disability hearing or a hearing before an administrative law judge shall not exceed the maximum amount allowable under this section for travel to the hearing site from any point within the geographic area of the office having jurisdiction over the hearing.

(i) The geographic area of the office having jurisdiction over the hearing means, as appropriate—

(A) The designated geographic service area of the State agency adjudicatory unit having responsibility for providing the disability hearing;

(B) If a Federal disability hearing officer holds the disability hearing, the geographic area of the State (which includes a State as defined in §404.2(c)(5) and also includes the Northern Mariana Islands) in which the claimant resides or, if the claimant is not a resident of a State, in which the hearing officer holds the disability hearing; or

(C) The designated geographic service area of the Office of Hearings and Appeals hearing office having responsibility for providing the hearing before an administrative law judge.

(ii) We or the State agency determine the maximum amount allowable for travel by a representative based on the distance to the hearing site from the farthest point within the appropriate geographic area. In determining the maximum amount allowable for travel between these two points, we or the State agency apply the rules in paragraphs (a) through (c) of this section and the limitations in paragraph (d) (1) and (4) of this section. If the distance between these two points does not exceed 75 miles, we or the State agency will not reimburse any of your representative's travel expenses.

(4) If a change in the location of the hearing is made at your request from the location we or the State agency selected to one farther from your residence or office, neither your additional travel expenses nor the additional travel expenses of your representative and witnesses will be reimbursed.

[51 FR 8808, Mar. 14, 1986, as amended at 59 FR 8532, Feb. 23, 1994]

§404.999d When and how to claim reimbursement.

(a)(1) Generally, you will be reimbursed for your expenses after your trip. However, travel advances may be authorized if you request prepayment and show that the requested advance is reasonable and necessary.

(2) You must submit to us or the State agency, as appropriate, an itemized list of what you spent and supporting receipts to be reimbursed.

(3) Arrangements for special means of transportation and related unusual costs may be made only if we or the State agency authorizes the costs in writing in advance of travel, unless the costs are unexpected or unavoidable. If

they are unexpected or unavoidable we or the State agency must determine their reasonableness and necessity and must approve them before payment may be made.

(4) If you receive prepayment, you must, within 20 days after your trip, provide to us or the State agency, as appropriate, an itemized list of your actual travel costs and submit supporting receipts. We or the State agency will require you to pay back any balance of the advanced amount that exceeds any approved travel expenses within 20 days after you are notified of the amount of that balance. (State agencies may have their own time limits in place of the 20-day periods in the preceding two sentences.)

(b) You may claim reimbursable travel expenses incurred by your representative for which you have been billed by your representative, except that if your representative makes a claim for them to us or the State, he or she will be reimbursed directly.

(Approved by the Office of Management and Budget under control number 0960–0434)

[51 FR 8809, Mar. 14, 1986, as amended at 51 FR 44983, Dec. 16, 1986]

Subpart K—Employment, Wages, Self-Employment, and Self-Employment Income

AUTHORITY: Secs. 202(v), 205(a), 209, 210, 211, 229(a), 230, 231, and 702(a)(5) of the Social Security Act (42 U.S.C. 402(v), 405(a), 409, 410, 411, 429(a), 430, 431, and 902(a)(5)).

SOURCE: 45 FR 20075, Mar. 27, 1980, unless otherwise noted.

§ 404.1001 Introduction.

(a)(1) In general, your social security benefits are based on your earnings that are on our records. (Subpart I of this part explains how we keep earnings records.) Basically, you receive credit only for earnings that are covered for social security purposes. The earnings are covered only if your work is covered. If you are an employee, your employer files a report of your covered earnings. If you are self-employed, you file a report of your covered earnings. Some work is covered by social security and some work is not. Also, some earnings are covered by social security and some are not. It is important that you are aware of what kinds of work and earnings are covered so that you will know whether your earnings should be on our records.

(2) If you are an employee, your covered work is called *employment*. This subpart explains our rules on the kinds of work that are covered as *employment* and the kinds that are not. We also explain who is an employee.

(3) If your work is *employment*, your covered earnings are called *wages*. This subpart explains our rules on the kinds of earnings that are covered as *wages* and the kinds that are not.

(4) If you work for yourself, you are self-employed. The subpart explains our rules on the kinds of self-employment that are covered and the kinds that are not.

(5) If you are self-employed, your covered earnings are called *self-employment income* which is based on your *net earnings from self-employment* during a taxable year. This subpart explains our rules on the kinds of earnings that are covered as *net earnings from self-employment* and the kinds that are not. We also explain how to figure your *net earnings from self-employment* and determine your *self-employment income* which is the amount that goes on our records.

(b) We include basically only the rules that apply to current work or that the law requires us to publish as regulations. We generally do not include rules that are seldom used or do not apply to current work because of changes in the law.

(c) The Social Security Act and the Internal Revenue Code (Code) have similar provisions on coverage of your earnings because the one law specifies the earnings for which you will receive credit for benefit purposes and the other the earnings on which you must pay social security taxes. Because the Code (title 26 U.S.C.) has some provisions that are not in the Act but which may affect you, you may need to refer to the Code or the Internal Revenue Service regulations (title 26 of the Code of Federal Regulations) to get complete information about your social security coverage.

(d) The rules are organized in the following manner:

(1) Sections 404.1003 through 404.1010 include the rules on employment. We discuss what we mean by employment, what work is covered as employment for social security purposes, and describe the kinds of workers who are considered employees.

(2) In §§ 404.1012 through 404.1038 we discuss various types of work that are not covered as employment for social security purposes.

(3) The rules on wages are found in §§ 404.1041 through 404.1059. We describe what is meant by the term *wages*, discuss the various types of pay that count as wages, and state when the pay counts for Social Security purposes. We include explanations of agriculture labor, domestic services, service not in the course of the employer's business, and home worker services under *wages* because special standards apply to these services.

(4) Our rules on self-employment and self-employment income are found in §§ 404.1065 through 404.1096. We discuss what we mean by self-employment, what we mean by a trade or business, what types of activities are considered self-employment, how to determine self-employment income, and how net earnings from self-employment are figured.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 61 FR 38365, July 24, 1996]

§ 404.1002 Definitions.

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

The *Act* means the Social Security Act, as amended.

The *Code* means the Internal Revenue Code of 1954, as amended.

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

You or *your* means any person whose earnings from employment or self-employment are included or excluded under social security.

(b) *Other definitions.* For ease of reference, we have placed other definitions in the sections of this subpart in which they are used.

EMPLOYMENT

§ 404.1003 Employment.

Employment means, generally, any service covered by social security performed by an employee for his or her employer. The rules on who is an employee and who is an employer are contained in §§ 404.1005 through 404.1010. Section 404.1004 states the general rule on the kinds of work covered as employment. Exceptions to the general rule are contained in §§ 404.1012 through 404.1038 which explain the kinds of work excluded from employment. All of these rules apply to current work unless otherwise indicated.

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38365, July 24, 1996]

§ 404.1004 What work is covered as employment.

(a) *General requirements of employment.* Unless otherwise excluded from coverage under §§ 404.1012 through 404.1038, the work you perform as an employee for your employer is covered as employment under social security if one of the following situations applies:

(1) You perform the work within the United States (whether or not you or your employer are a citizen or resident of the United States).

(2) You perform the work outside the United States and you are a citizen or resident of the United States working for—

(i) An American employer; or

(ii) A foreign affiliate of an American employer that has in effect an agreement covering your work under section 3121(l) of the Code.

(3) You perform the work on or in connection with an American vessel or American aircraft and the conditions in paragraphs (a)(3) (i) and (ii) are met. Your citizenship or residence does not matter. The citizenship or residence of your employer matters only if it affects whether the vessel is an American vessel.

(i) You enter into the contract of employment within the United States or the vessel or aircraft touches at a port or airport within the United States

during the performance of your contract of employment on the vessel or aircraft.

(ii) You are employed on and in connection with the vessel or aircraft when outside the United States.

(4) Your work is designated as employment or recognized as equivalent to employment under a totalization agreement. (See § 404.1913. An agreement may exempt work from coverage as well as extend coverage to work.)

(5) Your work performed after December 31, 1994, is in the employ of an international organization pursuant to a transfer from a Federal agency under section 3582 of title 5 of the United States Code and both the following are met:

(i) Immediately before the transfer, your work for the Federal agency was covered employment; and

(ii) You would be entitled, upon separation from the international organization and proper application, to reemployment with the Federal agency under section 3582.

(b) *Explanation of terms used in this section*—(1) *American employer* means—

(i) The United States or any of its instrumentalities;

(ii) A State, a political subdivision of a State, or an instrumentality of any one or more States or political subdivisions of a State;

(iii) An individual who is a resident of the United States;

(iv) A partnership, if at least two-thirds of the partners are residents of the United States;

(v) A trust, if all of the trustees are residents of the United States; or

(vi) A corporation organized under the laws of the United States or of any State.

(2) *American aircraft* means an aircraft registered under the laws of the United States.

(3) *American vessel* means a vessel documented or numbered under the laws of the United States. It also includes a vessel neither documented nor numbered under the laws of the United States, nor documented under the laws of any foreign country, if its crew is employed solely by one or more citizens or residents of the United States, or corporations organized under the laws of the United States or of any State.

(4) *Citizen of the United States* includes a citizen of the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa.

(5) *Foreign affiliate* refers to a foreign affiliate as defined in section 3121(l)(6) of the Code.

(6) *On and in connection with* refers to the performance of work on a vessel or aircraft which concerns the vessel or aircraft. Examples of this kind of work are the services performed on a vessel by employees as officers or crew members, or as employees of concessionaires, of the vessel.

(7) *On or in connection with* refers to work performed on the vessel or aircraft and to work which concerns the vessel or aircraft but not actually performed on it. For example, shore services in connection with repairing, loading, unloading, or provisioning a vessel performed by employees as officers or crew members, or as employees of concessionaires, of the vessel are included, since this work concerns the vessel though not performed on it.

(8) *State* refers to the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

(9) *United States* when used in a geographical sense means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36573, Sept. 9, 1985; 55 FR 51687, Dec. 17, 1990; 61 FR 38365, July 24, 1996]

§ 404.1005 Who is an employee.

You must be an employee for your work to be covered as employment for social security purposes. You are an employee if you are—

(a) A corporation officer as described in § 404.1006;

(b) A common-law employee as described in § 404.1007 (unless you are, after December 31, 1982, a qualified real estate agent or direct seller as described in § 404.1069); or

(c) An agent-driver or commission-driver, a full-time life insurance salesman, a home worker, or a traveling or city salesman as described in §404.1008.

[45 FR 20075, Mar. 27, 1980, as amended at 48 FR 40515, Sept. 8, 1983]

§404.1006 Corporation officer.

If you are an officer of a corporation, you are an employee of the corporation if you are paid or you are entitled to be paid for holding office or performing services. However, if you are a director of a corporation, we consider you to be self-employed when you work as a director.

§404.1007 Common-law employee.

(a) *General.* The common-law rules on employer-employee status are the basic test for determining whether you and the person or firm you work for have the relationship of employee and employer. Even though you are considered self-employed under the common-law rules, you may still be an employee for social security purposes under §404.1006 (relating to corporation officers) or §404.1008 (relating to workers in four specific jobs). In general, you are a common-law employee if the person you work for may tell you what to do and how, when, and where to do it. The person or firm you work for does not have to give these orders, but needs only the right to do so. Whether or not you are a common-law employee is not always clear. Several aspects of your job arrangement are considered in determining whether you are an employee or are self-employed under the common-law rules.

(b) *Factors that show employee status.* Some aspects of a job arrangement that may show you are an employee are as follows:

(1) The person you work for may fire you.

(2) The person you work for furnishes you with tools or equipment and a place to work.

(3) You receive training from the person you work for or are required to follow that person's instructions.

(4) You must do the work yourself.

(5) You do not hire, supervise, or pay assistants (unless you are employed as a foreman, manager, or supervisor).

(6) The person you work for sets your hours of work, requires you to work full-time, or restricts you from doing work for others.

(7) The person you work for pays your business or traveling expenses.

(8) You are paid by the hour, week or month.

(c) *Factors that show self-employed status.* Some aspects of a job arrangement or business venture that may show you are self-employed are as follows:

(1) You make a profit or suffer a loss.

(2) You are hired to complete a certain job and if you quit before the job is completed you may be liable for damages.

(3) You work for a number of persons or firms at the same time.

(4) You advertise to the general public that you are available to perform services.

(5) You pay your own expenses and have your own equipment and work place.

(d) *Questions about your status.* If there is a question about whether you are working as an employee or are self-employed, we or the Internal Revenue Service will make a determination after examining all of the facts of your case.

§404.1008 Agent-driver or commission-driver, full-time life insurance salesman, home worker, or traveling or city salesman.

(a) *General.* In addition to common-law employees and corporation officers, we consider workers in the four types of jobs described in paragraphs (b) through (e) of this section to be employees if their services are performed under the following conditions:

(1) Under the work arrangement the worker is expected to do substantially all of the work personally.

(2) The worker must not have a substantial investment in the facilities used to do the work. Facilities include such things as a place to work, storage space, equipment, machinery and office furniture. However, facilities do not include tools, equipment or clothing of the kind usually provided by employees nor transportation such as a car or truck.

(3) The work must be performed as part of a continuing work relationship between the worker and the person for

whom the work is done. The work performed must not be a single transaction. Part-time and regular seasonal work may be performed as part of a continuing work relationship.

(b) *Agent-driver or commission-driver.* This is a driver hired by another person to distribute meat products, vegetable products, fruit products, bakery products, beverages (other than milk), or laundry or dry-cleaning services. We consider you an agent-driver or commission-driver if you are paid a commission based on your sales or the difference between the price you charge your customers and the amount you pay for the goods or services. It makes no difference whether you drive your own truck or the company's truck or whether you solicit the customers you serve.

(c) *Full-time life insurance salesman.* A full-time life insurance salesman's main activity is selling life insurance or annuity contracts, or both, mostly for one life insurance company. If you are a full-time life insurance salesman, you are probably provided office space, stenographic help, telephone, forms, rate books and advertising materials by the company or general agent, without cost to you.

(d) *Home worker.* A home worker is a person who works away from the place of business of the person he or she works for, usually at home. If you are a home worker and you work according to the instructions of the person you work for, on material or goods furnished by that person, and are required to return the finished product to that person (or another person whom he or she designates), you are an employee.

(e) *Traveling or city salesman.* The main activity of a traveling or city salesman is taking orders for merchandise for another person or firm. The salesman gets orders from wholesalers, retailers, contractors, or operators of hotels, restaurants or other firms whose main business is furnishing food or lodging or both. The salesman sells merchandise to others for resale or for use in their own business. We consider you a traveling or city salesman if most of your work is done for a single person or firm even though you have incidental sideline sales activities. However, you are not an employee under this paragraph as to those sideline sales. If you take orders for a number of persons or firms as a *multiple line* salesman, you are not a traveling or city salesman.

§ 404.1009 Who is an employer.

A person is an employer if he or she employs at least one employee. Sometimes it is not clear who a worker's employer is, since the employer does not always pay the worker's wages. When there is a question about who the employer is, we use the common-law rules to identify the employer (see § 404.1007).

§ 404.1010 Farm crew leader as employer.

A farm crew leader furnishes workers to do agricultural labor for another person, usually a farm operator. If the crew leader pays the workers (the money can be the crew leader's or the farm operator's), the crew leader is deemed to be the employer of the workers and is self-employed. However, the crew leader is not deemed the employer of the workers if there is a written agreement between the crew leader and the farm operator naming the crew leader as an employee. If the crew leader does not have this agreement and does not pay the workers, we use the common-law rules to determine the crew leader's status.

WORK EXCLUDED FROM EMPLOYMENT

§ 404.1012 Work excluded from employment.

Certain kinds of work performed by an employee are excluded from employment. They are described in §§ 404.1014 through 404.1038 and are exceptions to the general rule in § 404.1004 on the kinds of work that are covered as employment. In general, if the work performed by an employee is excluded from employment, the work is not covered under social security. However, certain kinds of work performed by an employee, even though excluded from employment, are covered as self-employment for social security purposes. In addition, if part of the work performed by an employee for the same employer is included as employment and part is excluded from employment,

all the work may be included or all may be excluded as described in §404.1013.

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38365, July 24, 1996]

§404.1013 Included-excluded rule.

(a) If part of your work for an employer during a pay period is covered as employment and part excluded, all of your work during that period is considered covered if at least one-half of your time in the pay period is in covered work. If you spend most of your time in a pay period doing work that is excluded, all of your work in that period is excluded.

(b) A *pay period* is the period for which your employer ordinarily pays you. It cannot be more than 31 consecutive days. If the actual period is not always the same, your usual pay period will be used for applying the included-excluded rule.

(c) The included-excluded rule does not apply and your covered work will be counted if—

(1) Part of your work is covered by the Railroad Retirement Tax Act and part by the Social Security Act; or

(2) You have no usual *pay period* of 31 consecutive days or less, or you have separate pay periods for covered and excluded work.

§404.1014 Domestic service by a student for a local college club, fraternity or sorority.

(a) *General.* If you are a student and do work of a household nature in or about the club rooms or house of a local college club or local chapter of a college fraternity or sorority, and are enrolled and regularly attending classes at a school, college, or university, your work is not covered as employment.

(b) *Explanation of terms.* (1) *Work of a household nature* means the type of work done by cooks, waiters, butlers, maids, janitors, laundresses, furnacemen, handymen, gardeners, housekeepers and housemothers.

(2) A *local college club or local chapter of a college fraternity or sorority* does not include an alumni club or chapter. Also, if the club rooms or house are used mostly for supplying board or lodging to students or nonstudents as a business, the work done is not excluded by this section.

§404.1015 Family services.

(a) *General.* If you work as an employee of a relative, the work is excluded from employment if—

(1) You work while under age 18 in the employ of your parent;

(2) You do nonbusiness work (see §404.1058(a)(3) for an explanation of nonbusiness work) or perform domestic service (as described in §404.1057(b)) as an employee of your parent while under age 21;

(3) You do nonbusiness work as an employee of your son, daughter, or spouse; or

(4) You perform domestic service in the private home of your son, daughter or spouse as an employee of that son, daughter or spouse unless—

(i) The son or daughter has a child (either natural, adopted or stepchild) living in the home who is under age 18 or, if older, has a mental or physical condition that requires the personal care and supervision of an adult for at least four continuous weeks in the calendar quarter in which the work is done; and

(ii) The son or daughter is a widower or widow, or is divorced and has not remarried, or has a spouse living in the home who, because of a physical or mental condition, is incapable of taking care of the child and the condition is present for at least four continuous weeks in the calendar quarter in which the work is done.

(b) *Family work for other than sole proprietor.* Work for a corporation is not excluded under this section, and work for a partnership is not excluded unless the required family relationship exists between the employee and each of the partners.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§404.1016 Foreign agricultural workers.

Farm work done by foreign workers lawfully admitted to the United States on a temporary basis to do farm work is not covered as employment. The excluded work includes any services connected with farm operations.

§ 404.1017 Sharefarmers.

(a) If you are a sharefarmer, your services are not covered as employment, but as self-employment.

(b) You are a sharefarmer if you have an arrangement with the owner or tenant of the land and the arrangement provides for all of the following:

(1) You will produce agricultural or horticultural commodities on the land.

(2) The commodities you produce or the income from their sale will be divided between you and the person with whom you have the agreement.

(3) The amount of your share depends on the amount of commodities you produce.

(c) If under your agreement you are to receive a specific rate of pay, a fixed sum of money or a specific amount of the commodities not based on your production, you are not a sharefarmer for social security purposes.

§ 404.1018 Work by civilians for the United States Government or its instrumentalities—wages paid after 1983.

(a) *General.* If you are a civilian employee of the United States Government or an instrumentality of the United States, your employer will determine the amount of remuneration paid for your work and the periods in or for which such remuneration was paid. We will determine whether your employment is covered under Social Security, the periods of such covered employment, and whether remuneration paid for your work constitutes wages for purposes of Social Security. To make these determinations we will consider the date of your appointment to Federal service, your previous Federal employing agencies and positions (if any), whether you were covered under Social Security or a Federal civilian retirement system, and whether you made a timely election to join a retirement system established by the Federal Employees' Retirement System Act of 1986 or the Foreign Service Pension System Act of 1986. Using this information and the following rules, we will determine that your service is covered unless—

(1) The service would have been excluded if the rules in effect in January 1983 had remained in effect; and

(i) You have been continuously performing such service since December 31, 1983; or

(ii) You are receiving an annuity from the Civil Service Retirement and Disability Fund or benefits for service as an employee under another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(2) The service is under the provisions of 28 U.S.C. 294, relating to the assignment of retired Federal justices and judges to active duty.

(b) *Covered services*—(1) *Federal officials.* Any service for which you received remuneration after 1983 is covered if performed—

(i) As the President or the Vice President of the United States;

(ii) In a position placed in the Executive Schedule under 5 U.S.C. 5312 through 5317;

(iii) As a noncareer appointee in the Senior Executive Service or a noncareer member of the Senior Foreign Service;

(iv) In a position to which you are appointed by the President, or his designee, or the Vice President under 3 U.S.C. 105(a)(1), 106(a)(1), or 197 (a)(1) or (b)(1) if the maximum rate of basic pay for such position is at or above the rate for level V of the Executive Schedule;

(v) As the Chief Justice of the United States, an Associate Justice of the Supreme Court, a judge of a United States court of appeals, a judge of a United States district court, including the district court of a territory, a judge of the United States Claims Court, a judge of the United States Court of International Trade, a judge of the United States Tax Court, a United States magistrate, or a referee in bankruptcy or United States bankruptcy judge; or

(vi) As a Member, Delegate, or Resident Commissioner of or to the Congress.

(2) *Legislative Branch Employees.* Service you perform for the legislative branch of the Federal Government for which you are paid remuneration after 1983 is generally covered by Social Security if such service is not covered by the Civil Service Retirement System

or by another retirement system established by a law of the United States and in effect on December 31, 1983, for employees of the Federal Government other than a system for members of the uniformed services.

(3) *Election to become subject to the Federal Employees' Retirement System or the Foreign Service Pension System.* Your service is covered if:

(i) You timely elect after June 30, 1987, under either the Federal Employees' Retirement System Act or the Central Intelligence Agency Retirement Act, to become subject to the Federal Employees Retirement System provided in 5 U.S.C. 8401 through 8479; or

(ii) You timely elect after June 30, 1987, to become subject to the Foreign Service Pension System provided in 22 U.S.C. 4071 through 4071(k).

(4) *Subsequent Federal civilian service.* If you perform Federal civilian service on or after November 10, 1988, which is described in paragraph (b)(1), (b)(2), or (b)(3) of this section you will continue to be covered for any subsequent Federal Civilian Service not excluded under paragraph (c) of this section.

(c) *Excluded Service.* Notwithstanding §404.1018a and this section, your service is not covered if performed—

(1) In a penal institution of the United States as an inmate thereof;

(2) As an employee included under 5 U.S.C. 5351(2) relating to certain interns, student nurses, and other student employees of hospitals of the Federal Government, other than as a medical or dental intern or a medical or dental resident in training;

(3) As an employee serving on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency; or

(4) Under any other statutory provisions that would require exclusion for reasons other than being in the employ of the Federal Government or an instrumentality of such.

(d) *Work as a Peace Corps Volunteer.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, is covered as employment.

(e) *Work as Job Corps Enrollee.* Work performed as an enrollee in the Job Corps is considered to be performed in the employ of the United States.

(f) *Work by Volunteer in Service to America.* Work performed and training received as a Volunteer in Service to America is considered to be performed in the employ of the United States if the volunteer is enrolled for a period of service of at least 1 year. If the enrollment is for less than 1 year, we use the common-law rules in §404.1007 to determine the volunteer's status.

(g) *Work for international organizations.* Work performed for an international organization by an employee who was transferred from a Federal agency is generally covered as employment if, immediately before the transfer, the employee's services for the Federal agency were covered. (See §404.1004(a)(5) and §404.1034(c).)

(h) *Meaning of ''continuously performing''*—(1) *Absence of less than 366 days.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section if you return to the performance of such service after being separated from such service for a period of less than 366 consecutive days, regardless of whether the period began before, on, or after December 31, 1983.

(2) *Other absences.* You are considered to be continuously performing service described in paragraph (a)(1)(i) of this section regardless of the length of separation or whether the period of separation began before, on, or after December 31, 1983, if you—

(i) Return to the performance of such service after being detailed or transferred from such service to an international organization as described under 5 U.S.C. 3343 or under 5 U.S.C. 3581;

(ii) Are reemployed or reinstated after being separated from such service for the purpose of accepting employment with the American Institute of Taiwan as provided under 22 U.S.C. 3310;

(iii) Return to the performance of such service after performing service as a member of a uniformed service including service in the National Guard and temporary service in the Coast Guard Reserve and after exercising restoration or reemployment rights as provided under 38 U.S.C. chapter 43; or

(iv) Return to the performance of such service after employment by a tribal organization to which section 105(e)(2) of the Indian Self-Determination Act applies.

[53 FR 38944, Oct. 4, 1988; 53 FR 44551, Nov. 3, 1988, as amended at 55 FR 24891, June 19, 1990; 61 FR 38365, July 24, 1996]

§ 404.1018a Work by civilians for the United States Government or its instrumentalities—remuneration paid prior to 1984.

(a) *General—remuneration paid prior to 1984.* If you worked as a civilian employee of the United States Government or an instrumentality of the United States, your work was excluded from employment if that work was covered by a retirement system established by law. Your work for an instrumentality that was exempt from Social Security tax was also excluded. Certain other work for the United States or an instrumentality of the United States was specifically excluded and is described in this section.

(b) *Work covered by a retirement system—remuneration paid prior to 1984.* Work you did as an employee of the United States or an instrumentality of the United States was excluded from employment if the work was covered by a retirement system established by a law of the United States. If you had a choice as to whether your work was covered by the retirement system, the work was not covered by that system until you chose that coverage. In order for the exclusion to apply, the work you did, rather than the position you held, must have been covered by the retirement system.

(c) *Work that was specifically excluded—remuneration paid prior to 1984.* Work performed by an employee of the United States or an instrumentality of the United States was excluded if it was done—

(1) As the President or Vice President of the United States;

(2) As a Member of the United States Congress, a Delegate to Congress, or a Resident Commissioner;

(3) In the legislative branch of the United States Government;

(4) By a student nurse, student dietitian, student physical therapist or student occupational therapist who was assigned or attached to a Federal hospital, clinic, or medical or dental laboratory;

(5) By a person designated as a student employee with the approval of the Office of Personnel Management who was assigned or attached primarily for training purposes to a Federal hospital, clinic, or medical or dental laboratory, other than a medical or dental intern or resident in training;

(6) By an employee who served on a temporary basis in case of fire, storm, earthquake, flood, or other similar emergency;

(7) By a person to whom the Civil Service Retirement Act did not apply because the person's services were subject to another retirement system established by a law of the United States or by the instrumentality of the United States for which the work was done, other than the retirement system established by the Tennessee Valley Authority under the plan approved by the Secretary of Health, Education, and Welfare on December 28, 1956; or

(8) By an inmate of a penal institution of the United States, if the work was done in the penal institution.

(d) *Work for instrumentalities of the United States exempt from employer tax—remuneration paid prior to 1984.* (1) Work performed by an employee of an instrumentality of the United States was excluded if—

(i) The instrumentality was exempt from the employer tax imposed by section 3111 of the Code or by section 1410 of the Internal Revenue Code of 1939; and

(ii) The exemption was authorized by another law specifically referring to these sections.

(2) Work performed by an employee of an instrumentality of the United States was excluded if the instrumentality was not on December 31, 1950, subject to the employer tax imposed by section 1410 of the Internal Revenue Code of 1939 and the work was covered by a retirement system established by the instrumentality, unless—

(i) The work was for a corporation wholly owned by the United States;

(ii) The work was for a Federal land bank association, a production credit association, a Federal Reserve Bank, a Federal Credit Union, a Federal land

bank, a Federal intermediate credit bank, a bank for cooperatives, or a Federal Home Loan Bank;

(iii) The work was for a State, county, or community committee under the Agriculture Marketing Service and the Commodity Stabilization Service, formerly the Production and Marketing Administration; or

(iv) The work was by a civilian, who was not paid from funds appropriated by the Congress, in activities conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense or Secretary of Transportation at installations intended for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Defense Department or the Coast Guard, such as—

(A) Army and Air Force Exchange Service;

(B) Army and Air Force Motion Picture Service;

(C) Coast Guard Exchanges;

(D) Navy Ship's Service Stores; and

(E) Marine Corps Post Exchanges.

(3) For purposes of paragraph (d)(2) of this section, if an employee has a choice as to whether his or her work was covered by a retirement system, the work was not covered by that system until he or she chose that coverage. The work done, rather than the position held, must have been covered by the retirement system.

(e) *Work as a Peace Corps Volunteer—remuneration paid prior to 1984.* Work performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, 22 U.S.C. 2501 through 2523, was covered as employment.

(f) *Work as Job Corps Enrollee—remuneration paid prior to 1984.* Work performed as an enrollee in the Job Corps was considered to be performed in the employ of the United States.

(g) *Work by Volunteer in Service to America—remuneration paid prior to 1984.* Work performed and training received as a Volunteer in Service to America was considered to be performed in the employ of the United States if the volunteer was enrolled for a period of service of at least one year. If the enrollment was for less than one year, we used the common-law rules in §404.1007 to determine the volunteer's status.

[53 FR 38945, Oct. 4, 1988]

§404.1018b Medicare qualified government employment.

(a) *General.* The work of a Federal, State, or local government employee not otherwise subject to Social Security coverage may constitute Medicare qualified government employment. Medicare qualified government employment means any service which in all ways meets the definition of ''employment'' for title II purposes of the Social Security Act, except for the fact that the service was performed by a Federal, State or local government employee. This employment is used solely in determining eligibility for protection under part A of title XVIII of the Social Security Act (Hospital Insurance) and for coverage under the Medicare program for end-stage renal disease.

(b) *Federal employment.* If, beginning with remuneration paid after 1982, your service as a Federal employee is not otherwise covered employment under the Social Security Act, it is Medicare qualified government employment unless excluded under §404.1018(c).

(c) *State and local government employment.* If, beginning with service performed after March 31, 1986, your service as an employee of a State or political subdivision (as defined in §404.1202(b)), Guam, American Samoa, the District of Columbia, or the Northern Mariana Islands is excluded from covered employment solely because of section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments (note §§404.1020 through 404.1022), it is Medicare qualified government employment except as provided in paragraphs (c) (1) and (2) of this section.

(1) An individual's service shall not be treated as employment if performed—

(i) By an individual employed by a State or political subdivision for the purpose of relieving that individual from unemployment;

(ii) In a hospital, home, or other institution by a patient or inmate thereof as an employee of a State, political

subdivision, or of the District of Columbia;

(iii) By an individual, as an employee of a State, political subdivision or the District of Columbia serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) By an individual as an employee included under 5 U.S.C. 5351(2) (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia government), other than as a medical or dental intern or a medical or dental resident in training; or

(v) By an election official or election worker paid less than $100 in a calendar year for such service prior to 1995, or less than $1,000 for service performed in any calendar year after 1994 and before 2000, or, for service performed in any calendar year after 1999, less than the $1,000 base amount, as adjusted pursuant to section 218(c)(8)(B) of the Social Security Act to reflect changes in wages in the economy. We will publish this adjustment of the $1,000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

(2) An individual's service performed for an employer shall not be treated as employment if—

(i) The service would be excluded from coverage under section 210(a)(7) of the Social Security Act which pertains to employees of State and local governments;

(ii) The service is performed by an individual who—

(A) Was performing substantial and regular service for remuneration for that employer before April 1, 1986;

(B) Was a bona fide employee of that employer on March 31, 1986; and

(C) Did not enter into the employment relationship with that employer for purposes of meeting the requirements of paragraphs (c)(2)(ii) (A) and (B) of this section; and

(iii) After March 31, 1986, but prior to the service being performed, the employment relationship with that employer had not been terminated.

[57 FR 59913, Dec. 17, 1992, as amended at 61 FR 38366, July 24, 1996]

§ 404.1019 Work as a member of a uniformed service of the United States.

(a) Your work as a member of a uniformed service of the United States is covered under Social Security (unless creditable under the Railroad Retirement Act), if—

(1) On or after January 1, 1957, the work is service on active duty or active duty for training but not including service performed while on leave without pay; or

(2) On or after January 1, 1988, the work is service on inactive duty training.

(b) You are a *member of a uniformed service* if—

(1) You are appointed, enlisted, or inducted into (or a retired member of)—

(i) One of the armed services (Army, Navy, Air Force, Marine Corps, or Coast Guard); or

(ii) A component of one of the armed services, including any reserve component as defined in Veterans' Benefits, 38 U.S.C. 101 (except the Coast Guard Reserve as a temporary member);

(2) You are a commissioned officer (including a retired commissioned officer) of the National Oceanic and Atmospheric Administration or the Regular or Reserve Corps of the Public Health Service;

(3) You are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(4) You are a cadet at the United States Military, Coast Guard, or Air Force Academy, or a midshipman at the United States Naval Academy;

(5) You are a member of the Reserve Officers Training Corps, the Naval Reserve Officers Training Corps, or the Air Force Reserve Officers Training Corps, when ordered to annual training duty for 14 days or more including periods of authorized travel to and from that duty; or

(6) You are selected for active military or naval training under the Military Selective Service Act or are provisionally accepted for active duty in the military or naval service and you are ordered or directed to a place for final acceptance or entry upon active duty and are on the way to or from, or at, that place.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59913, Dec. 17, 1992]

§404.1020 Work for States and their political subdivisions and instrumentalities.

(a) *General.* If you work as an employee of a State, a political subdivision of a State, or any wholly owned instrumentality of one or more of these, your work is excluded from employment unless—

(1) The work is covered under an agreement under section 218 of the Act (see subpart M of this part); or

(2) The work is *covered transportation service* as defined in section 210(k) of the Act (see paragraph (c) of this section).

(3) You perform services after July 1, 1991, as an employee of a State (other than the District of Columbia, Guam, or American Samoa), a political subdivision of a State, or any wholly owned instrumentality of one or more of the foregoing and you are not a member of a retirement system of such State, political subdivision, or instrumentality. Retirement system has the meaning given that term in section 218(b)(4) of the Act, except as provided in regulations prescribed by the Secretary of the Treasury. This paragraph does not apply to services performed—

(i) As an employee employed to relieve you from unemployment;

(ii) In a hospital, home, or other institution where you are a patient or inmate thereof;

(iii) As an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or other similar emergency;

(iv) As an election official or election worker if the remuneration paid in a calendar year for such service prior to 1995 is less than $100, or less than $1000 for service performed in any calendar year after 1994 and before 2000, or, for service performed in any calendar year after 1999, less than the $1000 base amount, as adjusted pursuant to section 218(c)(8)(B) of the Social Security Act to reflect changes in wages in the economy. We will publish this adjustment of the $1000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

(v) As an employee in a position compensated solely on a fee basis which is treated, pursuant to section 211(c)(2)(E) of the Act, as a trade or business for purposes of inclusion of the fees in net earnings from self-employment; or

(4) The work is covered under §404.1021 or §404.1022.

(b) *Medicare qualified government employment.* Notwithstanding the provisions of paragraph (a) of this section, your work may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

(c) *Covered transportation service*—(1) *Work for a public transportation system.* If you work for a public transportation system of a State or political subdivision of a State, your work may be covered transportation service if all or part of the system was acquired from private ownership. You must work as an employee of the State or political subdivision in connection with its operation of a public transportation system for your work to be covered transportation service. This paragraph sets out additional conditions that must be met for your work to be covered transportation service. If you work for a public transportation system but your work is not covered transportation service, your work may be covered for social security purposes under an agreement under section 218 of the Act (see subpart M of this part).

(2) *Transportation system acquired in whole or in part after 1936 and before 1951.* All work after 1950 for a public transportation system is covered transportation service if—

(i) Any part of the transportation system was acquired from private ownership after 1936 and before 1951; and

(ii) No general retirement system covering substantially all work in connection with the operation of the transportation system and guaranteed by the State constitution was in effect on December 31, 1950.

(3) *Transportation system operated on December 31, 1950, no part of which was acquired after 1936 and before 1951.* If no part of a transportation system operated by a State or political subdivision on December 31, 1950, was acquired from private ownership after 1936 and before 1951, work for that public transportation system is not covered transportation service unless performed under conditions described in paragraph (b)(4) of this section.

(4) *Addition after 1950 to existing transportation system.* Work for a public transportation system part of which was acquired from private ownership after 1950 as an addition to an existing transportation system is covered transportation service beginning with the first day of the third calendar quarter following the calendar quarter in which the addition was acquired if—

(i) The work is performed by an employee who—

(A) Worked in employment in connection with the operation of the addition before the addition was acquired by the State or political subdivision; and

(B) Became an employee of the State or political subdivision in connection with and at the time of its acquisition of the addition;

(ii) On that first day, work performed by that employee is—

(A) Not covered by a general retirement system; or

(B) Covered by a general retirement system which contains special provisions that apply only to employees described in paragraph (c)(4)(i)(B) of this section;

(iii) The existing transportation system was operated by the State or political subdivision on December 31, 1950; and

(iv) Work for the existing transportation system was not covered transportation service because—

(A) No part of the system was acquired from private ownership after 1936 and before 1951; or

(B) The general retirement system described in paragraph (c)(2)(ii) of this section was in effect on December 31, 1950.

(5) *Transportation system acquired after 1950.* All work for a public transportation system is covered transportation service if—

(i) The transportation system was not operated by the State or political subdivision before 1951;

(ii) All or part of the transportation system was first acquired from private ownership after 1950; and

(iii) At the time the State or political subdivision first acquired any part of its transportation system from private ownership, it did not have a general retirement system covering substantially all work performed in connection with the operation of the transportation system.

(6) *Definitions.* (i) The term *general retirement system* means any pension, annuity, retirement, or similar fund or system established by a State or by a political subdivision of a State for employees of the State, the political subdivision, or both. The term does not include a fund or system which covers only work performed in positions connected with the operation of the public transportation system.

(ii) A transportation system (or part of a system) is considered to have been acquired from private ownership by a State or political subdivision if—

(A) Before the acquisition, work performed by employees in connection with the operation of the system (or an acquired part) constituted employment under the Act; and

(B) Some of these employees became employees of the State or political subdivision in connection with and at the time of the acquisition.

(iii) The term *political subdivision* includes an instrumentality of a State, of one or more political subdivisions of a State, or of a State and one or more of its political subdivisions.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, 59914, Dec. 17, 1992; 61 FR 38366, July 24, 1996]

§ 404.1021 Work for the District of Columbia.

If you work as an employee of the District of Columbia or a wholly owned instrumentality of the District of Columbia, your work is covered as employment unless—

(a) Your work is covered by a retirement system established by a law of the United States; or

(b) You are—

(1) A patient or inmate of a hospital or penal institution and your work is for that hospital or institution;

(2) A student employee (a student nurse, dietitian, or physical or occupational therapist, but not a medical or dental intern or resident in training) of a District of Columbia hospital, clinic, or medical or dental laboratory;

(3) An employee serving temporarily in case of fire, storm, snow, earthquake, flood, or other similar emergency; or

(4) A member of a board, committee, or council of the District of Columbia paid on a per diem, meeting, or other fee basis.

(c) *Medicare qualified government employment.* If your work is not covered under Social Security, it may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992]

§404.1022 American Samoa or Guam.

(a) *Work in American Samoa or Guam.* Work in American Samoa or Guam for a private employer is covered as employment the same as in the 50 States. Work done by a resident of the Republic of the Philippines working in Guam on a temporary basis as a nonimmigrant alien admitted to Guam under section 101(a)(15)(H)(ii) of the Immigration and Nationality Act is excluded from coverage regardless of the employer.

(b) *Work for American Samoa or a political subdivision or wholly owned instrumentality of American Samoa.* Work as an officer or employee (including a member of the legislature) of the government of American Samoa, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is covered as employment (unless the work is covered by a retirement system established by a law of the United States). The officer or employee is not considered as an employee of the United States, an agency of the United States, or an instrumentality of the United States, for purposes of title II of the Act. We consider any pay for this work to have been paid by the government of American Samoa, or the political subdivision or the wholly owned instrumentality of American Samoa.

(c) *Work for Guam or a political subdivision or wholly owned instrumentality of Guam.* Work as an officer or employee (including a member of the legislature) of the government of Guam, its political subdivisions, or any wholly owned instrumentality of any one or more of these, is excluded from coverage as employment. However, the exclusion does not apply to employees classified as temporary or intermittent unless the work is—

(1) Covered by a retirement system established by a law of Guam;

(2) Done by an elected official;

(3) Done by a member of the legislature; or

(4) Done in a hospital or penal institution by a patient or inmate of the hospital or penal institution.

(d) *Medicare qualified government employment.* If your work is not covered under Social Security, it may be covered as Medicare qualified government employment (see §404.1018b(c) of this subpart).

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59914, Dec. 17, 1992]

§404.1023 Ministers of churches and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church, the work you do in the exercise of your ministry is excluded from employment. However, it is treated as self-employment for social security purposes. If you are a member of a religious order who has not taken a vow of poverty, the same rule applies to the work you do in the exercise of your duties required by that order. If you are a member of a religious order who has taken a vow of poverty, the work you do in the exercise of duties required by the order (the work may be done for the order or for another employer) is covered as employment only if the order or autonomous subdivision of the order to which you belong has filed an effective election of coverage. The election is made under section 3121(r) of the Code. For the rules on self-employment coverage of ministers and members of religious orders who have not taken vows of poverty, see §404.1071.

(b) *What is an ordained, commissioned, or licensed minister.* The terms *ordained, commissioned, or licensed* describe the procedures followed by recognized churches or church denominations to vest ministerial status upon qualified individuals. If a church or church denomination has an ordination procedure, the commissioning or licensing of

a person as a minister may not make him or her a commissioned or licensed minister for purposes of this subpart. Where there is an ordination procedure, the commissioning or licensing must be recognized as having the same effect as ordination and the person must be fully qualified to exercise all of the ecclesiastical duties of the church or church denomination.

(c) *When is work by a minister in the exercise of the ministry*. (1) A minister is working in the exercise of the ministry when he or she is—

(i) Ministering sacerdotal functions or conducting religious worship (other than as described in paragraph (d)(2) of this section); or

(ii) Working in the control, conduct, and maintenance of a religious organization (including an integral agency of a religious organization) under the authority of a religious body constituting a church or church denomination.

(2) The following rules are used to decide whether a minister's work is in the exercise of the ministry:

(i) Whether the work is the conduct of religious worship or the ministration of sacerdotal functions depends on the tenets and practices of the religious body which is his or her church or church denomination.

(ii) Work in the control, conduct, and maintenance relates to directing, managing, or promoting the activities of the religious organization. Any religious organization is considered to be under the authority of a religious body constituting a church or church denomination if it is organized and dedicated to carrying out the tenets and principles of a faith according to either the requirements or sanctions governing the creation of institutions of the faith.

The term *religious organization* has the same meaning and application as is given to the term for income tax purposes under the Code.

(iii) If a minister is working in the conduct of religious worship or the ministration of sacerdotal functions, the work is in the exercise of the ministry whether or not it is performed for a religious organization. (See paragraph (d)(2) of this section for an exception to this rule.)

Example: M, a duly ordained minister, is engaged to work as chaplain at a privately owned university. M spends his entire time working as chaplain. This includes the conduct of religious worship, offering spiritual counsel to the university students, and teaching a class in religion. M is working in the exercise of the ministry.

(iv) If a minister is working for an organization which is operated as an integral agency of a religious organization under the authority of a religious body constituting a church or church denomination, all work by the minister in the conduct of religious worship, in the ministration of sacerdotal functions, or in the control, conduct, and maintenance of the organization is in the exercise of the ministry.

Example: M, a duly ordained minister, is engaged by the N Religious Board as director of one of its departments. M performs no other service. The N Religious Board is an integral agency of O, a religious organization operating under the authority of a religious body constituting a church denomination. M is working in the exercise of the ministry.

(v) If a minister, under an assignment or designation by a religious body constituting a church, works for an organization which is neither a religious organization nor operated as an integral agency of a religious organization, all service performed by him or her, even though the service may not involve the conduct of religious worship or the ministration of sacerdotal functions, is in the exercise of the ministry.

Example: M, a duly ordained minister, is assigned by X, the religious body constituting M's church, to perform advisory service to Y company in connection with the publication of a book dealing with the history of M's church denomination. Y is neither a religious organization nor operated as an integral agency of a religious organization. M performs no other service for X or Y. M is working in the exercise of the ministry.

(vi) If a minister is working for an organization which is neither a religious organization nor operated as an integral agency of a religious organization and the work is not performed under an assignment or designation by ecclesiastical superiors, then only the work done by the minister in the conduct of religious worship or the ministration of sacerdotal functions is in the exercise of the ministry. (See paragraph

(d)(2) of this section for an exception to this rule.)

Example: M, a duly ordained minister, is engaged by N University to teach history and mathematics. M does no other work for N although from time to time M performs marriages and conducts funerals for relatives and friends. N University is neither a religious organization nor operated as an integral agency of a religious organization. M is not working for N under an assignment by his ecclesiastical superiors. The work performed by M for N University is not in the exercise of the ministry. However, service performed by M in performing marriages and conducting funerals is in the exercise of the ministry.

(d) *When is work by a minister not in the exercise of the ministry.* (1) Work performed by a duly ordained, commissioned, or licensed minister of a church which is not in the exercise of the ministry is not excluded from employment.

(2) Work performed by a duly ordained, commissioned, or licensed minister of a church as an employee of the United States, or a State, territory, or possession of the United States, or the District of Columbia, or a foreign government, or a political subdivision of any of these, is not in the exercise of the ministry, even though the work may involve the ministration of sacerdotal functions or the conduct of religious worship. For example, we consider service performed as a chaplain in the Armed Forces of the United States to be work performed by a commissioned officer and not by a minister in the exercise of the ministry. Also, service performed by an employee of a State as a chaplain in a State prison is considered to be performed by a civil servant of the State and not by a minister in the exercise of the ministry.

(e) *Work in the exercise of duties required by a religious order.* Work performed by a member of a religious order in the exercise of duties required by the order includes all duties required of the member of the order. The nature or extent of the work is immaterial so long as it is service which the member is directed or required to perform by the member's ecclesiastical superiors.

§404.1024 Election of coverage by religious orders.

A religious order whose members are required to take a vow of poverty, or any autonomous subdivision of that religious order, may elect to have social security coverage extended to the work performed by its members in the exercise of duties required by that order or subdivision. The rules on the election of coverage by these religious orders are described in 26 CFR 31.3121(r). The rules on determining the wages of members of religious orders for which an election of coverage has been made are described in §404.1046.

§404.1025 Work for religious, charitable, educational, or certain other organizations exempt from income tax.

(a) *After 1983.* Work done after 1983 by an employee in the employ of a religious, charitable, educational, or other organization described in section 501(c)(3) of the Code which is exempt from income tax under section 501(a) of the Code is covered as employment unless the work is for a church or church-controlled organization that has elected to have services performed by its employees excluded (see §404.1026). (See §404.1059(b) for special wage rule.)

(b) *Before 1984.* Work described in paragraph (a) of this section which was done before 1984 is excluded from employment. However, the exclusion does not apply to work done during the period for which a form SS–15, Certificate Waiving Exemption From Taxes Under the Federal Insurance Contributions Act, was filed (or was deemed to have been filed) with the Internal Revenue Service.

[50 FR 36573, Sept. 9, 1985]

§404.1026 Work for a church or qualified church-controlled organization.

(a) *General.* If you work for a church or qualified church-controlled organization, as described in this section, your employer may elect to have your services excluded from employment. You would then be considered to be self-employed and special conditions would apply to you. See §404.1068(f) for those special conditions. The employer's election of the exclusion must be

made with the Internal Revenue Service in accordance with Internal Revenue Service procedures and must state that the church or church-controlled organization is opposed for religious reasons to the payment of Social Security employment taxes. The exclusion applies to current and future employees. If you work in an unrelated trade or business (within the meaning of section 513(a) of the Code) of the church or church-controlled organization, the exclusion does not apply to your services.

(b) *What is a church.* For purposes of this section the term *church* means a church, a convention or association of churches, or an elementary or secondary school which is controlled, operated, or principally supported by a church or by a convention or association of churches.

(c) *What is a qualified church-controlled organization.* For purposes of this section the term *qualified church-controlled organization* means any church-controlled organization exempt from income tax under section 501(c)(3) of the Code but does *not* include an organization which:

(1) Offers goods, services, or facilities for sale to the general public, other than on an incidental basis, or for other than a nominal charge which is substantially less than the cost of providing such goods, services, or facilities; and

(2) Normally receives more than 25 percent of its support from either governmental sources or receipts from admissions, sales of merchandise, performance of services or furnishing of facilities other than in an unrelated trade or business, or both.

[50 FR 36573, Sept. 9, 1985, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1027 Railroad work.

We exclude from employment any work you do as an employee or employee representative as described in the Railroad Retirement Tax Act. However, railroad compensation can be counted for social security purposes under the conditions described in subpart O of this part.

§ 404.1028 Student working for a school, college, or university.

(a) For purposes of this section, a *school, college, or university* has its usual accepted meaning. It does not, however, include any school, college, or university that is an instrumentality or integral part of a State or a political subdivision of a State for which work can only be covered by an agreement under section 218 of the Act. (See subpart M of this part.)

(b) If you are a student, any work you do as an employee of a school, college or university is excluded from employment, if you are enrolled in and regularly attending classes at that school, college, or university. The exclusion also applies to work you do for a private nonprofit auxiliary organization of the school, college, or university if it is organized and operated exclusively for the benefit of, to perform functions of, or to carry out the purposes of the school, college, or university. The organization must be operated, supervised, or controlled by, or in connection with, the school, college, or university.

(c) Whether you are a student for purposes of this section depends on your relationship with your employer. If your main purpose is pursuing a course of study rather than earning a livelihood, we consider you to be a student and your work is not considered employment.

§ 404.1029 Student nurses.

If you are a student nurse, your work for a hospital or nurses training school is excluded from employment if you are enrolled and regularly attending classes in a nurses training school which is chartered or approved under State law.

§ 404.1030 Delivery and distribution or sale of newspapers, shopping news, and magazines.

(a) *If you are under age 18.* Work you do before you reach age 18 delivering or distributing newspapers or shopping news is excluded from employment. This does not include delivery or distribution to some point for further delivery or distribution by someone else. If you make house-to-house delivery or sale of newspapers or shopping news

(including handbills and similar kinds of advertising material), your work is not covered while you are under age 18. Related work such as assembling newspapers is also excluded.

(b) *If you are any age.* No matter how old you are, work you do in connection with and at the time of the sale of newspapers or magazines to consumers is excluded from employment if there is an arrangement under which—

(1) You are to sell the newspapers or magazines at a fixed price; and

(2) Your pay is the difference between the fixed selling price and the amount you are charged for the newspapers or magazines (whether or not you are guaranteed a minimum amount of compensation or receive credit for unsold newspapers or magazines).

(c) *If you are age 18 or older.* If you have attained age 18, you are self-employed if you work under the arrangement described in paragraph (b) of this section. See §404.1068(b).

§404.1031 Fishing.

(a) If you work on a boat engaged in catching fish or other forms of aquatic animal life, your work is not employment if you have an arrangement with the owner or operator of the boat which provides for all of the following:

(1) You do not receive any cash pay (other than as provided in paragraph (a)(2) of this section).

(2) You receive a share of the catch or a share of the proceeds from the sale of the catch.

(3) The amount of your share depends on the size of the catch.

(4) The operating crew of the boat (or each boat from which you receive a share if the fishing operation involves more than one boat) is normally made up of fewer than 10 individuals.

(b) Work excluded from employment under this section is considered to be self-employment (§404.1068(e)).

§404.1032 Work for a foreign government.

If you work as an employee of a foreign government in any capacity, your work is excluded from employment. If you are a citizen of the United States and work in the United States as an employee of a foreign government, you are considered to be self-employed (§404.1068(d)).

§404.1033 Work for a wholly owned instrumentality of a foreign government.

(a) If you work as an employee of an instrumentality of a foreign government, your work is excluded from employment if—

(1) The instrumentality is wholly owned by the foreign government;

(2) Your work is similar to work performed in foreign countries by employees of the United States Government or its instrumentalities; and

(3) The Secretary of State certifies to the Secretary of the Treasury that the foreign government grants an equivalent exemption for services performed in the foreign country by employees of the United States Government or its instrumentalities.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) If you are a citizen of the United States and work in the United States as an employee of an instrumentality of a foreign government and the conditions in paragraph (a) of this section are met, you are considered to be self-employed (§404.1068(d)).

§404.1034 Work for an international organization.

(a) If you work as an employee of an international organization entitled to enjoy privileges, exemptions, and immunities as an international organization under the International Organizations Immunities Act (59 Stat. 669), your work is excluded from employment except as described in paragraphs (b) and (c) of this section. The organization must meet the following conditions:

(1) It must be a public international organization in which the United States participates under a treaty or authority of an act of Congress authorizing, or making an appropriation for, participation.

(2) It must be designated by executive order to be entitled to enjoy the privileges, exemptions, and immunities provided in the International Organizations Immunities Act.

(3) The designation must be in effect, and all conditions and limitations in the designation must be met.

(b) Your work will not be excluded under this section if any of the conditions in paragraph (a) of this section are not met.

(c) Your work performed after December 31, 1994 will not be excluded under this section if you perform service in the employ of an international organization pursuant to a transfer from a Federal agency under section 3582 of title 5 of the United States Code and

(1) Immediately before such transfer you performed service with a Federal agency which was covered as employment; and

(2) You would be entitled, upon separation from the international organization and proper application, to reemployment with the Federal agency under section 3582.

(d) If you are a citizen of the United States and work in the United States as an employee of an international organization that meets the conditions in paragraph (a) of this section and you are not subject to coverage based on paragraph (c) of this section, you are considered to be self-employed (§ 404.1068(d)).

[45 FR 20075, Mar. 27, 1980, as amended at 61 FR 38366, July 24, 1996]

§ 404.1035 Work for a communist organization.

If you work as an employee of an organization which is registered, or which is required by a final order of the Subversive Activities Control Board to register under the Internal Security Act of 1950 as a communist action, communist-front, or communist-infiltrated organization, your work is excluded from employment. The exclusion is effective with the calendar year in which the organization is registered or the final order is in effect.

§ 404.1036 Certain nonresident aliens.

(a) *Foreign students.* (1) Foreign students (nonimmigrant aliens) may be temporarily in the United States under subparagraph (F) of section 101(a)(15) of the Immigration and Nationality Act to attend a school or other recognized place of study approved by the Attorney General. On-campus work or work under permission granted by the Immigration and Naturalization Service which is done by these students is excluded from employment. Other work done by these foreign students is not excluded from employment under this section.

(2) Foreign students (nonimmigrant aliens) may be temporarily in the United States under subparagraph (M) of section 101(a)(15) of the Immigration and Nationality Act to pursue a vocational or nonacademic technical education approved by the Attorney General. Work done by these students to carry out the purpose for which they were admitted is excluded from employment. Other work done by these foreign students is not excluded from employment under this section.

(b) *Exchange visitors.* (1) Exchange visitors (nonimmigrant aliens) may be temporarily in the United States under subparagraph (J) of section 101(a)(15) of the Immigration and Nationality Act to participate in exchange visitor programs designated by the Director of the United States Information Agency. Work done by these exchange visitors to carry out the purpose for which they were admitted and for which permission has been granted by the sponsor, is excluded from employment. Other work done by these exchange visitors is not excluded from employment under this section.

(2) Exchange visitors (nonimmigrant aliens) may be temporarily in the United States under subparagraph (Q) of section 101(a)(15) of the Immigration and Nationality Act to participate in an international cultural exchange program approved by the Attorney General. Effective October 1, 1994, work done by these exchange visitors to carry out the purpose for which they were admitted is excluded from employment. Other work done by these exchange visitors is not excluded from employment under this section.

(c) *Spouse and children.* Work done by a foreign student's or exchange visitor's alien spouse or minor child who is also temporarily in the United States under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act is not excluded from employment under this section

unless that spouse or child and the work that is done meets the conditions of paragraph (a) or (b) of this section.

[61 FR 38366, July 24, 1996]

§404.1037 Work on or in connection with a non-American vessel or aircraft.

If you work as an employee within the United States on or in connection with (as explained in §404.1004(b)(8)) a vessel or aircraft that is not an American vessel (as defined in §404.1004(b)(3)) or American aircraft (as defined in §404.1004(b)(2)), your work is excluded from employment if—

(a) You are not a citizen of the United States or your employer is not an American employer (as defined in §404.1004(b)(1)); and

(b) You are employed on and in connection with (as explained in §404.1004(b)(7)) the vessel or aircraft when outside the United States.

§404.1038 Domestic employees under age 18.

Domestic services you perform in a private home of your employer are excluded from employment, regardless of the amount earned, in any year in which you are under age 18 if domestic service is not your principal occupation. The exclusion applies to the entire year if you are under age 18 in any part of the year. See §404.1057.

[61 FR 38366, July 24, 1996]

EXEMPTION FROM SOCIAL SECURITY BY REASON OF RELIGIOUS BELIEF

§404.1039 Employers (including partnerships) and employees who are both members of certain religious groups opposed to insurance.

(a) You and your employer (or, if the employer is a partnership, each of its partners) may file applications with the Internal Revenue Service for exemption from your respective shares of the Federal Insurance Contributions Act taxes on your wages paid by that employer if you and your employer (or, if the employer is a partnership, each of its partners)—

(1) Are members of a recognized religious sect or division of the sect; and

(2) Adhere to the tenets or teachings of the sect or division of the sect and for that reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payment in the event of death, disability, old-age, or retirement; or

(ii) Makes payment for the cost of, or provides services for, medical care including the benefits of any insurance system established by the Act.

(b) Both your application and your employer's application (or, if your employer is a partnership, each partner's application) must be filed with and approved by the Internal Revenue Service pursuant to section 3127 of the Internal Revenue Code. An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See §404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether the applicant meets all these conditions, the application will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause the applicant to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section; and

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members that is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) An application for exemption will be approved by the Internal Revenue Service only if no benefit or payment under title II or part A of title XVIII of the Act became payable (or, but for section 203 or section 222(b) of the Act, would have become payable) to the applicant at or before the time of the filing of the application for exemption.

(e) The tax exemption ceases to be effective with respect to wages paid beginning with the calendar quarter in which either the employer (or if the employer is a partnership, any of its partners) or the employee involved does not meet the requirements of

paragraph (a) of this section or the religious sect or division of the sect is found by us to no longer meet the requirements of paragraph (c) of this section. If the tax exemption ceases to be effective, the waiver of the right to receive Social Security and Medicare Part A benefits will also no longer be effective. Benefits may be payable based upon the wages of the individual, whose exempt status was terminated, for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon the self-employment income of the individual whose exempt status was terminated for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[58 FR 64889, Dec. 10, 1993]

WAGES

§ 404.1041 Wages.

(a) The term *wages* means remuneration paid to you as an employee for employment unless specifically excluded. Wages are counted in determining your entitlement to retirement, survivors', and disability insurance benefits.

b) If you are paid wages, it is not important what they are called. Salaries, fees, bonuses and commissions on sales or on insurance premiums are wages if they are remuneration paid for employment.

(c) The way in which you are paid is unimportant. Wages may be paid on the basis of piecework or a percentage of the profits. Wages may be paid on an hourly, daily, weekly, monthly, or yearly basis. (See § 404.1056 for special rules for agricultural labor.)

(d) Your wages can be in any form. You can be paid in cash or something other than cash, for example, in goods or clothing. (See paragraphs (e) and (f) of this section for kinds of employment where cash payments alone are considered wages and § 404.1043(b) concerning the value of meals and lodging as wages.) If your employer pays you cash for your meals and lodging on a regular basis as part of your employment, these payments may be considered wages. Payments other than cash may be counted as wages on the basis of the fair value of the items when paid.

(e) In certain kinds of employment, cash payments alone count as wages. These types of employment are agricultural labor, domestic services, and services not in the course of the employer's trade or business.

(f) To count as wages, payments for services performed by home workers who are employees as described in § 404.1008(d) must be in cash and must amount to $100 or more in a calendar year. Once this cash pay test is met, all remuneration paid, whether in cash or kind, is also wages.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990]

§ 404.1042 Wages when paid and received.

(a) *In general.* Wages are received by an employee at the time they are paid by the employer to the employee. Wages are paid by an employer at the time that they are actually or constructively paid unless they are deemed to be paid later (as described in paragraph (c)(3) of this section).

(b) *Constructive payment.* Wages are constructively paid when they are credited to the account of, or set aside for, an employee so that they may be drawn upon by the employee at any time although not then actually received. To be a payment—

(1) The wages must be credited to or set aside for the employee and must be made available without restriction so that they may be drawn upon at any time; or

(2) The employer must intend to pay or to set aside or credit, and have the ability to pay wages when due to the employee, and failure of the employer to credit or set aside the wages is due to clerical error or mistake in the mechanics of payment, and because of the clerical error or mistake the wages are not actually available at that time.

(c) *Deemed payment.* (1) The first $100 of cash paid, either actually or constructively, by an employer to an employee in a calendar year is considered paid at the time that the amount of the cash payment totals $100 for the year in the case of pay for—

(i) Work not in the course of the employer's trade or business (non-business work);

(ii) Work by certain home workers; and

(iii) Work for an organization exempt from income tax under section 501 of the Code.

(2) We also apply this rule to domestic work in a private home of the employer, except see §404.1057(a)(1) for the applicable dollar amount.

(3) Cash of less than $150 that an employer pays to an employee in a calendar year, either actually or constructively, for agricultural labor is considered paid at the earliest of—

(i) The time in the calendar year that the employee's pay totals $150; or

(ii) The 20th day of the calendar year on which the employee works for cash pay computed on a time basis.

(4) If an employer pays cash to an employee for two or more of the kinds of work referred to in paragraph (c)(1) of this section, we apply the provisions of this paragraph to the pay for each kind of work.

(d) *Employee tax deductions.* We consider employee tax deductions under section 3101 of the Code to be part of the employee's wages and consider them to be paid at the time of the deduction. We consider other deductions from wages to be wages paid at the time of the deduction. It is immaterial that the deductions are required or permitted by an act of Congress or the law of any State.

(e) *Tips.* (1) Tips received by an employee in the course of employment, that are considered to be *wages,* are deemed to be paid at the time the employee reports the tips to the employer in a written statement as provided under section 6053(a) of the Code. Tips that are not reported are deemed to be paid to the employee at the time they are received by the employee.

(2) We consider tips to be received in the course of employment whether they are received by the employee from the employer or from another person. Only tips employees receive and keep for themselves are considered to be the employees' pay. If employees split tips, each employee who receives part of the tip receives tips in the course of employment.

(f) *Payments under nonqualified deferred compensation plans.* Amounts that an employee is entitled to receive under nonqualified deferred compensation plans (plans that do not qualify for special tax treatment under the Code) are creditable as wages for Social Security purposes at the later of the following times:

(1) When the services are performed; or

(2) When there is no longer a substantial risk of forfeiture (as defined in section 83 of the Code) of the employee's rights to the deferred compensation.

Any amounts taken into account as wages by this paragraph (and the income attributable thereto) will not thereafter be treated as wages for Social Security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 61 FR 38366, July 24, 1996]

§404.1043 Facilities or privileges—meals and lodging.

(a) *Excluding the value of employer provided facilities or privileges from employee gross income prior to January 1, 1985.* (1) Generally, the facilities or privileges that an employer furnished an employee prior to January 1, 1985 are not wages if the facilities or privileges—

(i) Were of relatively small value; and

(ii) Were offered or furnished by the employer merely as a means of promoting the health, good will, contentment, or efficiency of the employees.

(2) The term *facilities or privileges* for the period prior to January 1, 1985 is intended to include such items as entertainment, medical services, and so-called *courtesy* discounts on purchases.

(b) *Meals and lodging.* The value of the meals and lodging furnished to an employee by an employer for reasons of the employer's convenience is not wages if—

(1) The meals are provided at the employer's place of business; and

(2) The employee, in the case of lodging, is required to accept lodging on the employer's business premises as a condition of employment.

[52 FR 29662, Aug. 11, 1987]

§ 404.1044 Vacation pay.

We consider your salary while on vacation, or a *vacation allowance* paid by your employer, to be wages.

§ 404.1045 Employee expenses.

Amounts that your employer pays you specifically—either as advances or reimbursements—for traveling or for other ordinary and necessary expenses incurred, or reasonably expected to be incurred, in your employer's business are not wages. The employer must identify these travel and other expenses either by making a separate payment or by specifically stating the separate amounts if both wages and expense allowances are combined in a single payment.

§ 404.1046 Pay for work by certain members of religious orders.

(a) If you are a member of a religious order who has taken a vow of poverty (§ 404.1023), and the order has elected Social Security coverage under section 3121(r) of the Code, your wages are figured in a special way. Your wages, for Social Security purposes, are the fair market value of any board, lodging, clothing, and other items of value furnished to you by the order, or furnished to the order on your behalf by another organization or person under an agreement with the order. See paragraph (b) of this section if you perform services for a third party. The order must report at least $100 a month for each active member. If the fair market value of items furnished to all members of a religious order does not vary significantly, the order may consider all members to have a uniform wage.

(b) If you perform services for a third party, the following rules apply:

(1) If you perform services for another agency of the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, do not count on wages. Only wages figured under (a) above, are counted.

(2) If you perform services in a secular setting as an employee of a third party not affiliated or associated with the supervising church or an associated institution, any amounts paid based on such services, whether paid directly to you or to the order, count as wages paid to you by the third party. These wages are in addition to any wages counted under paragraph (a) of this section.

[55 FR 7309, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§ 404.1047 Annual wage limitation.

Payments made by an employer to you as an employee in a calendar year that are more than the annual wage limitation are not wages. The annual wage limitation is:

Calendar year	Wage limitation
1951–54	$3,600
1955–58	4,200
1959–65	4,800
1966–67	6,600
1968–71	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700
1982	32,400
1983	35,700
1984	37,800
1985	39,600
1986	42,000
1987	43,800
1988	45,000
1989	48,000
1990	51,300
1991	53,400
1992	55,500

[52 FR 8249, Mar. 17, 1987, as amended at 57 FR 44098, Sept 24, 1992]

§ 404.1048 Contribution and benefit base after 1992.

(a) *General.* The contribution and benefit base after 1992 is figured under the formula described in paragraph (b) of this section in any calendar year in which there is an automatic cost-of-living increase in old-age, survivors, and disability insurance benefits. For purposes of this section, the calendar year in which the contribution and benefit base is figured is called the determination year. The base figured in the determination year applies to wages paid after (and taxable years beginning after) the determination year.

(b) *Formula for figuring the contribution and benefit base.* For wages paid

after (and taxable years beginning after) the determination year, the contribution and benefit base is the larger of—

(1) The contribution and benefit base in effect for the determination year; or

(2) The amount determined by—

(i) Multiplying the contribution and benefit base in effect for the determination year by the ratio of—

(A) The average of the total wages (as described in paragraph (c) of this section) reported to the Secretary of the Treasury for the calendar year before the determination year to

(B) The average of the total wages reported to the Secretary of the Treasury for the calendar year before the most recent calendar year in which an increase in the contribution and benefit base was enacted or a determination under this section resulting in an increase of the base was made; and

(ii) Rounding the result of the multiplication, if not a multiple of $300, to—

(A) The nearest multiple of $300; or

(B) The next higher multiple of $300 if the result is a multiple of $150.

(c) *Average of the total wages.* The average of the total wages means the amount equal to all remuneration reported as wages on Form W–2 to the Internal Revenue Service for all employees for income tax purposes plus contributions to certain deferred compensation plans described in section 209(k) of the Social Security Act (also reported on Form W–2), divided by the number of wage earners. If both distributions from and contributions to any such deferred compensation plan are reported on Form W–2, we will include only the contributions in the calculation of the average of the total wages. The reported remuneration and deferred compensation contributions include earnings from work not covered under social security and earnings from work covered under social security that are more than the annual wage limitation described in §404.1047.

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7309, Mar. 1, 1990; 57 FR 1382, Jan. 14, 1992]

§404.1049 Payments under an employer plan or system.

(a) Payments to, or on behalf of, you or any of your dependents under your employer's plan or system are excluded from wages if made because of your or your dependents'—

(1) Medical or hospitalization expenses connected with sickness or accident disability; or

(2) Death, except that the exclusion does not apply to payments for group-term life insurance to the extent that the payments are includible in the gross income of the employee under the Internal Revenue Code of 1986, effective with respect to group-term life insurance coverage in effect after 1987 for employees whose employment, for the employer (or successor of that employer) providing the insurance coverage, does not end prior to 1989. Such payments are wages, however, if they are for coverage for an employee who was separated from employment prior to January 1, 1989, if the payments are for any period for which the employee is reemployed by the employer (or successor of that employer) after the date of separation.

(b) Payments to you or your dependents under your employer's plan at or after the termination of your employment relationship because of your death or retirement for disability are excluded from wages.

(c) Payments made after 1983 to you or your dependents under your employer's plan at or after the termination of your employment relationship because of retirement after reaching an age specified in the plan or in a pension plan of the employer are not excluded from wages unless—

(1) The payments are to or from a trust or annuity plan of your employer as described in §404.1052; or

(2) An agreement to retire was in effect on March 24, 1983, between you and your employer and the payments made after 1983 under a nonqualified deferred compensation plan (see §404.1042(f)) are based on services performed for your employer before 1984.

(d) The plan or system established by the employer must provide for the employees generally or for a class or classes of employees. The plan or system may also provide for these employees' dependents. Payments under a plan or system established only for your dependents are not excluded from wages. The plan or system established

by the employer can provide for payments on account of one or more of the items in paragraphs (a) and (b) of this section.

(e) For purposes of this section, your dependents include your husband or wife, children, and any other members of your immediate family.

(f) It does not make any difference that the benefit payments are considered in arriving at the amount of your pay or are required by the employment agreement.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 1832, Jan. 14, 1985; 55 FR 7310, Mar. 1, 1990; 55 FR 17530, Apr. 25, 1990]

§ 404.1050 Retirement payments.

Payments made after 1983 to you (including any amount paid by an employer for insurance or annuities) on account of your retirement for age are not excluded from wages unless—

(a) The payments are to or from a trust or annuity plan of your employer as described in § 404.1052; or

(b) The payments satisfy the requirements described in § 404.1049(c)(2).

[55 FR 7310, Mar. 1, 1990]

§ 404.1051 Payments on account of sickness or accident disability, or related medical or hospitalization expenses.

(a) We do not include as wages any payment that an employer makes to you, or on your behalf, on account of your sickness or accident disability, or related medical or hospitalization expenses, if the payment is made more than 6 consecutive calendar months following the last calendar month in which you worked for that employer. Payments made during the 6 consecutive months are included as wages.

(b) The exclusion in paragraph (a) of this section also applies to any such payment made by a third party (such as an insurance company). However, if you contributed to your employer's sick pay plan, that portion of the third party payments attributable to your contribution is not wages.

(c) Payments of medical or hospitalization expenses connected with sickness or accident disability are excluded from wages beginning with the first payment only if made under a plan or system of your employer as explained in § 404.1049(a)(1).

(d) Payments under a worker's compensation law are not wages.

[55 FR 7310, Mar. 1, 1990]

§ 404.1052 Payments from or to certain tax-exempt trusts or payments under or into certain annuity plans.

(a) We do not include as wages any payment made—

(1) Into a tax-exempt trust or annuity plan by your employer on behalf of you or your beneficiary; or

(2) From a tax-exempt trust or under an annuity plan to, or on behalf of, you or your beneficiary.

(b) The trust must be exempt from tax under sections 401 and 501(a) of the Code, and the annuity plan must be a plan described in section 403(a) of the Code when payment is made.

(c) The exclusion does not apply to payments to an employee of the trust for work done as an employee of the trust.

[55 FR 7310, Mar. 1, 1990]

§ 404.1053 "Qualified benefits" under a cafeteria plan.

We do not include as wages any *qualified benefits* under a cafeteria plan as described in section 125 of the Code if such payment would not be treated as wages without regard to such plan and it is reasonable to believe that (if section 125 applied for purposes of this section) section 125 would not treat any wages as constructively received. This includes any *qualified benefit* made to you, or on your behalf, pursuant to a salary reduction agreement between you and your employer. The Internal Revenue Service decides whether any plan is a cafeteria plan under section 125 of the Code and whether any benefit under the plan is a *qualified benefit*.

[55 FR 7310, Mar. 1, 1990]

§ 404.1054 Payments by an employer of employee's tax or employee's contribution under State law.

(a) We exclude as wages any payment by an employer (described in paragraph (b) of this section) that is not deducted from the employee's salary (or for which reimbursement is not made by the employee) of either—

(1) The tax imposed by section 3101 of the Code (employee's share of *Social Security tax*); or

(2) Any payment required from an employee under a State unemployment compensation law.

(b) The payments described in paragraph (a) of this section are not included as wages only if they are made by an employer on behalf of an employee employed in—

(1) Domestic service in the private home of the employer; or

(2) Agricultural labor.

[55 FR 7310, Mar. 1, 1990]

§404.1055 Payments for agricultural labor.

(a) *When cash payments are not wages.* We do not include as wages your cash payments in a calendar year after 1987 from an employer for agricultural labor (see §404.1056) if your employer's total expenditures for agricultural labor are less than $2500 in that year and your employer paid you less than $150 cash remuneration in that year for your agricultural labor. If you perform domestic service in the private home of an employer on a farm operated for profit, we do not include as wages the cash payments for those services if they are less than the applicable dollar threshold described in §404.1057(a).

(b) *Exclusions for noncash payments and payments for seasonal agricultural labor.* (1) Noncash payments for agricultural labor are not wages.

(2) Your cash payments in a calendar year from an employer for agricultural labor are not wages, irrespective of your employer's total annual expenditures for agricultural labor, if you are a hand harvest laborer (i.e., seasonal agricultural labor), and—

(i) Your employer paid you less than $150 in that year;

(ii) You are paid on a piece rate basis in an operation which has been, and is customarily and generally recognized in the region of employment as paying on a piece rate basis;

(iii) You commute daily from your permanent residence to the farm on which you are so employed; and,

(iv) You were employed in agriculture less than 13 weeks during the previous calendar year.

Example: In 1988, A (not a hand harvest laborer) performs agricultural labor for X for cash pay of $144 in the year. X's total agricultural labor expenditures for 1988 are $2,450. Neither the $150 cash-pay test nor the $2,500 expenditures test is met. Therefore, X's payments to A are not wages.

(c) *When cash-pay is creditable as wages.* (1) If you receive cash pay from an employer for services which are agricultural labor and for services which are not agricultural labor, we count only the amounts paid for agricultural labor in determining whether cash payments equal or exceed $150. If the amounts paid are less than $150, we count only those amounts paid for agricultural labor in determining if the $2500 expenditure test is met.

Example: Employer X operates a store and also operates a farm. Employee A, who regularly works in the store, works on X's farm when additional help is required for the farm activities. In calendar year 1988, X pays A $140 cash for agricultural labor performed in that year, and $2,260 for work in connection with the operation of the store. Additionally, X's total expenditures for agricultural labor in 1988 were $2,010. Since the cash payments by X to A in the calendar year 1988 for agricultural labor are less than $150, and total agricultural labor expenditures were under $2,500, the $140 paid by X to A for agricultural labor is not wages. The $2,260 paid for work in the store is wages.

(2) The amount of cash pay for agricultural labor that is creditable to an individual is based on cash paid in a calendar year rather than on amounts earned during a calendar year.

(3) If you receive cash pay for agricultural labor in any one calendar year from more than one employer, we apply the $150 cash-pay test and $2,500 total expenditures test to each employer.

(d) *Application of the $150 cash-pay and 20-day tests prior to 1988.* (1) For the time period prior to 1988, we apply either the $150 a year cash-pay test or the 20-day test. Cash payments are wages if you receive $150 or more from an employer for agricultural labor or under the 20-day test if you perform agricultural labor for which cash pay is computed on a time basis on 20 or more days during a calendar year. For purposes of the 20-day test, the amount of the cash pay is immaterial, and it is immaterial whether you also receive

payments other than cash or payments that are not computed on a time basis. If cash paid to you for agricultural labor is computed on a time basis, the payments are not wages unless they are paid in a calendar year in which either the 20-day test or the $150 cash-pay test is met.

(2) [Reserved]

[57 FR 59914, Dec. 17, 1992, as amended at 61 FR 38367, July 24, 1996]

§ 404.1056 Explanation of agricultural labor.

(a) *What is agricultural labor.* (1) If you work on a farm as an employee of any person, you are doing agricultural labor if your work has to do with—

(i) Cultivating the soil;

(ii) Raising, shearing, feeding, caring for, training or managing livestock, bees, poultry, fur-bearing animals or wildlife; or

(iii) Raising or harvesting any other agricultural or horticultural commodity.

(2) If you work on a farm as an employee of any person in connection with the production or harvesting of maple sap, the raising or harvesting of mushrooms, or the hatching of poultry, you are doing agricultural labor. If you work in the processing of maple sap into maple syrup or maple sugar you are not doing agricultural labor even though you work on a farm. Work in a mushroom cave or poultry hatchery is agricultural labor only if the cave or hatchery is operated as part of a farm.

(3) If you work as an employee of the owner, tenant, or other operator of a farm, you are doing agricultural labor if most of your work is done on a farm and is involved with—

(i) The operation, management, conservation, improvement, or maintenance of the farm or its tools or equipment (this may include work by carpenters, painters, mechanics, farm supervisors, irrigation engineers, bookkeepers, and other skilled or semi-skilled workers); or

(ii) Salvaging timber or clearing the land of brush and other debris left by a hurricane.

(4) You are doing agricultural labor no matter for whom or where you work, if your work involves—

(i) Cotton ginning;

(ii) Operating or maintaining ditches, canals, reservoirs, or waterways, if they are used only for supplying and storing water for farm purposes and are not owned or operated for profit; or

(iii) Producing or harvesting crude gum (oleoresin) from living trees or processing the crude gum into gum spirits of turpentine and gum resin (if the processing is done by the original producer).

(5) Your work as an employee in the handling, planting, drying, packing, packaging, processing, freezing, grading, storing, or delivering to storage, to a market or to a carrier for transportation to market, of any agricultural or horticultural commodity is agricultural labor if—

(i) You work for a farm operator or a group of farm operators (other than a cooperative organization);

(ii) Your work involves the commodity in its raw or unmanufactured state; and

(iii) The operator produced most of the commodity you work with during the period for which you are paid, or if you work for a group of operators, all of the commodity you work with during the pay period is produced by that group.

(6) If you do nonbusiness work or domestic work in the private home of your employer, it is agricultural labor if you do the work on a farm operated for profit. However, if you do domestic work in the private home of your employer on a farm operated for profit, coverage of your earnings for the domestic services is determined in the same manner as earnings for any other domestic employee. Whether those earnings are covered will be determined based on the threshold described in § 404.1057(a) and the other coverage rules applicable to domestic service instead of the threshold applicable to other agricultural employees. A farm is not operated for profit if the employer primarily uses it as a residence or for personal or family recreation or pleasure. (See § 404.1057 for an explanation of domestic work and § 404.1058(a) for an explanation of nonbusiness work.)

(7) The term *farm operator* means an owner, tenant, or other person, in possession of and operating a farm.

(8) Work is not *agricultural labor* if it is done in the employ of a cooperative organization, which includes corporations, joint-stock companies, and associations treated as corporations under the Code. Any unincorporated group of operators is considered to be a cooperative organization if more than 20 operators are in the group at any time during the calendar year in which the work is done.

(9) Processing work which changes the commodity from its raw or natural state is not agricultural labor. An example of this is the extraction of juices from fruits or vegetables. However, work in the cutting and drying of fruits or vegetables does not change the commodity from its raw or natural state and can be agricultural labor.

(10) The term *commodity* means a single agricultural or horticultural product. For example, all apples are a commodity, while apples and oranges are two commodities.

(11) Work connected with the commerical canning or freezing of a commodity is not agricultural labor nor is work done after the delivery of the commodity to a terminal market for distribution for consumption.

(b) *What is a farm.* For purposes of social security coverage, *farm* includes a stock, dairy, poultry, fruit, fur-bearing animal, or truck farm, plantation, ranch, nursery, range or orchard. A farm also includes a greenhouse or other similar structure used mostly for raising agricultural or horticultural products. A greenhouse or other similar structure used mostly for other purposes such as display, storage, making wreaths and bouquets is not a farm.

[45 FR 20075, Mar. 27, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990, as amended at 61 FR 38367, July 24, 1996]

§404.1057 Domestic service in the employer's home.

(a) *Payments for domestic service*—(1) *The applicable dollar threshold.* We do not include as wages cash payments that an employer makes to you in any calendar year for domestic service in the employer's private home if the cash pay in that calendar year is less than the applicable dollar threshold. The threshold per employer is $1000 in calendar year 1995. In calendar years after 1995, this amount will be subject to adjustment in $100 increments based on the formula in section 215(a)(1)(B)(i) of the Act to reflect changes in wages in the economy. Non-cash payments for domestic service are not counted as wages.

(2) *How evaluation is made.* We apply the applicable dollar threshold described in paragraph (a)(1) of this section based on when the payments are made to you rather than when the pay is earned. To count toward the applicable dollar threshold, payment must be made to you in cash (including checks or other forms of money). We apply the applicable dollar threshold only to services performed as a domestic employee. If an employer pays you for performing other work, the cash pay for the nondomestic work does not count toward the applicable dollar threshold domestic service pay required for the remuneration to count as wages.

(3) *More than one domestic employer.* The applicable dollar threshold as explained in paragraph (a)(1) of this section applies to each employer when you perform domestic services for more than one employer in a calendar year. The wages paid by more than one employer for domestic services may not be combined to decide whether you have been paid the applicable dollar threshold or more in a calendar year. The standard applies to each employee when an employer has two or more domestic employees during a calendar year.

(4) *Rounding dollar amounts for reporting.* For social security purposes, an employer has an option in the way he or she reports cash wages paid for domestic service in his or her private home. The employer may report the actual wages paid or may round the wages to the nearest dollar. For purposes of rounding to the nearest dollar the cents are disregarded unless it amounts to one-half dollar or more, in which case it will be raised to $1. If an employer uses this method to report a cash payment to you for domestic services in his or her private home in a calendar year, he or she must use the same method to report payments to other employees in that year for similar services.

(b) *What is domestic service.* Domestic service is work of a household nature done by you in or about a private home of the employer. A private home is a fixed place of residence of a person or family. A separate dwelling unit maintained by a person in an apartment house, hotel, or other similar establishment may be a private home. If a house is used primarily for supplying board or lodging to the public as a business enterprise, it is not a private home. In general, services of a household nature in or about a private home include services performed by cooks, waiters, butlers, housekeepers, governessess, maids, valets, baby sitters, janitors, laundresses, furnacemen, caretakers, handymen, gardeners, footmen, grooms, and chauffeurs of automobiles for family use. Pay for these services does not come under this provision unless the services are performed in or about a private home of the employer. Pay for services not of a household nature, such as services performed as a private secretary, tutor, or librarian, even though performed in the employer's home, does not come under this provision.

[45 FR 20075, Mar. 27, 1980; 45 FR 25060, Apr. 14, 1980. Redesignated at 55 FR 7310, Mar. 1, 1990, as amended at 61 FR 38367, July 24, 1996]

§ 404.1058 Special situations.

(a) *Payments for service not in course of employer's trade or business (nonbusiness work) and payments to certain home workers*—(1) *The $100 standard.* We do not include as wages cash pay of less than $100 paid to you in a calendar year by an employer for services not in the course of the employer's trade or business (nonbusiness work) and for services as a home worker as described in § 404.1008(d).

(2) *How evaluation is made.* (i) We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To count toward the $100 amount, payment must be in cash (including checks or other forms of money). The $100 standard applies to each employer when you perform services not in the course of the employer's trade or business or as a homeworker for two or more employers.

(ii) If the employer has two or more employees, the standard applies to each employee. In applying the $100 standard, we disregard cash payments for any other type of services you perform for the employer.

(iii) The noncash payments an employer pays you for services not in the course of the employer's trade or business are not wages even if the employer has paid you cash wages of $100 or more in the calendar year for services of that type.

(iv) Amounts paid to you as a home worker as described in § 404.1008(d) are not wages unless you are paid $100 or more in cash in a calendar year. If you meet this test, any noncash payments you receive for your services also count as wages.

(v) Amounts paid to you as a home worker in a common-law employment relationship (see § 404.1007) count as wages regardless of amount or whether paid in cash or kind.

(3) *Definitions.* The term *services not in the course of the employer's trade or business* (also called nonbusiness work) means services that do not promote or advance the trade or business of the employer. Services performed for a corporation do not come within this definition. A homeworker is described in § 404.1008(c).

(b) *Nonprofit, income-tax exempt organizations*—(1) *The $100 standard.* We do not include as wages payments of less than $100 in a calendar year made by an employer that is an organization exempt from income tax under section 501 of the Code.

(2) *How evaluation is made.* We apply the $100 standard for a calendar year based on when the payments are made to you rather than when the pay is earned. To figure the $100 amount, both cash and noncash payments are counted. The $100 standard applies to each employer where you render services for two or more nonprofit, income-tax exempt organizations during a calendar year. The $100 standard also applies to each of you where a nonprofit, income-tax exempt organization has two or more employees. In applying the standard, the tax-exempt status of the employer and not the nature or place of your services is controlling.

(c) *Payments to members of the uniformed services*—(1) *The standard.* We include as the wages of a member of the uniformed services—

(i) Basic pay, as explained in paragraph (c)(3) of this section, for performing the services described in paragraph (a)(1) of § 404.1019 of this subpart; or

(ii) Compensation, as explained in paragraph (c)(4) of this section, for performing the services described in paragraph (a)(2) of § 404.1019 of this subpart.

(2) *Wages deemed paid.* These following provisions apply to members of the uniformed services who perform services as described in paragraph (a)(1) of § 404.1019 of this subpart.

(i) After 1977, a member of the uniformed services is considered to have been paid additional wages of $100 for each $300 of basic pay paid to the individual in a calendar year. The amount of additional wages deemed paid cannot be more than $1,200 for any calendar year. No wages may be deemed paid for units of basic pay which are less than $300.

(ii) Before 1978, a member of the uniformed services is considered to have been paid additional wages of $300 for each calendar quarter after 1956 in which the individual is paid any amount of basic pay.

(3) *Basic pay. Basic pay* means the monthly pay prescribed by 37 U.S.C. 203 (Pay and Allowances for the Uniformed Services) for a member of the uniformed services on active duty or on active duty for training.

(4) *Compensation.* ''Compensation'' refers to the remuneration received for services as a member of a uniformed service, based on regulations issued by the Secretary concerned (as defined in 37 U.S.C. 101(5) under 37 U.S.C. 206(a), where such member is not entitled to the basic pay (as defined by paragraph (3) of this section).

(d) *Payments to volunteers and volunteer leaders in the Peace Corps.* If you are a *volunteer* or *volunteer leader* under the provisions of the Peace Corps Act (*22 U.S.C. 2501ff*), payments for your services are wages with the exception of amounts in excess of the amounts certified as payable under section 5(*c*) or 6(*1*) of the Peace Corps Act. Amounts certified under those sections are considered to have been paid to the individual at the time the service is performed. See § 404.1018(*e*) on coverage of these services.

(e) *Moving expenses.* We do not include as wages amounts paid to, or on behalf of, an employee for moving expenses if it is reasonable to believe that a similar deduction is allowable under section 217 of the Code.

(f) *Payments by employer to survivor or estate of former employee.* We do not include as wages any payment by an employer to a survivor or the estate of a former employee after the calendar year in which the employee died.

(g) *Payments to an employee who is entitled to disability insurance benefits.* We do not include as wages any payments made by an employer to an employee if at the time such payment is made—

(1) The employee is entitled to disability insurance benefits under the Act;

(2) The employee's entitlement to such benefits began before the calendar year in which the employer's payment is made; and

(3) The employee performed no work for the employer in the period in which the payments were paid by such employer (regardless of whether the employee worked in the period the payments were earned).

(h) *Tips.* (1) We include as wages tips received by an employee if—

(i) The tips are paid in cash; and

(ii) The tips amount to $20 or more and are received in the course of employment by an employee in a calendar month.

(2) Cash tips include checks and other forms of money. Tips received in a form other than cash, such as passes, tickets, or other goods are not wages. If an employee works for more than one employer in a calendar month, we apply the $20 tip test to work done for each employer.

(i) *Payments by employer under group legal services plan.* We do not include as wages any contribution, payment, or service, provided by an employer under a qualified group legal services plan

which is excludable from the gross income of an employee, or the employee's spouse or dependents, under section 120 of the Code.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated and amended at 55 FR 7310, Mar. 1, 1990; 57 FR 59914, Dec. 17, 1992]

§ 404.1059 Deemed wages for certain individuals interned during World War II.

(a) *In general.* Persons who were interned during any period of time from December 7, 1941, through December 31, 1946, by the United States Government at a place operated by the Government within the United States for the internment of United States citizens of Japanese ancestry are deemed to have been paid wages (in addition to wages actually paid) as provided in paragraph (c) of this section during any period after attaining age 18 while interned. This provision is effective for determining entitlement to, and the amount of, any monthly benefit for months after December 1972, for determining entitlement to, and the amount of, any lump-sum death payment in the case of a death after December 1972, and for establishing a period of disability.

(b) *Information needed to process deemed wages.* Unless we have already made a determination on deemed wages for a period of internment of an individual, any person applying for a monthly benefit, a recalculation of benefits by reason of this section, or a lump-sum death payment, must submit certain information before the benefit or payment may be computed on the basis of deemed wages. This information is—

(1) The place where the individual worked before internment;

(2) The highest hourly wage before internment;

(3) The place and date of internment;

(4) Date of birth (if not previously furnished);

(5) Whether or not another Federal benefit is being received based wholly or in part upon the period of internment; and

(6) In the case of a woman, her maiden name.

(c) *Amount of deemed wages.* The amount of wages which may be deemed is determined as follows:

(1) *Employed prior to internment.* If the individual was employed before being interned, the deemed wages are the greater of—

(i) The highest actual hourly rate of pay received for any employment before internment, multiplied by 40 for each full week during the period of internment; or

(ii) The Federal minimum hourly rate in effect for the period of internment, multiplied by 40 for each full week during that period.

(2) *Self-employed or not employed prior to internment.* If the individual was self-employed or was not employed before the period of internment, the deemed wages are the Federal minimum hourly rate in effect for that period, multiplied by 40 for each full week during the period.

(d) *When wages are not deemed.* Wages are not deemed under this section—

(1) For any period before the quarter in which the individual attained age 18; or

(2) If a larger benefit is payable without the deemed wages; or

(3) If a benefit based in whole or in part upon internment is determined by any agency of the United States to be payable under any other law of the United States or under a system set up by that agency. However, this exception does not apply in cases where the failure to receive deemed wages reduces the primary insurance amount by 50 cents or less.

(e) *Certification of internment.* The certification concerning the internment is made by the Archivist of the United States or his or her representative. After the internment has been verified, wages are deemed to have been paid to the internee.

[45 FR 20075, Mar. 27, 1980, as amended at 52 FR 29662, Aug. 11, 1987. Redesignated at 55 FR 7310, Mar. 1, 1990]

§404.1060 [Reserved]

SELF-EMPLOYMENT

§404.1065 Self-employment coverage.

For an individual to have self-employment coverage under social security, the individual must be engaged in a trade or business and have net earnings from self-employment that can be counted as self-employment income for social security purposes. The rules explaining whether you are engaged in a trade or business are in §§404.1066 through 404.1077. What are net earnings from self-employment is discussed in §§404.1080 through 404.1095. Section 404.1096 describes the net earnings from self-employment that are counted as self-employment income for social security purposes. See §404.1913 for the effect of a totalization agreement on self-employment coverage. An agreement may exempt an activity from coverage as well as extend coverage to an activity.

[50 FR 36574, Sept. 9, 1985]

§404.1066 Trade or business in general.

For you to be covered as a self-employed person for social security purposes, you must be engaged in a trade or business. You can carry on a trade or business as an individual or as a member of a partnership. With some exceptions, the term *trade or business* has the same meaning as it does when used in section 162 of the Code.

§404.1068 Employees who are considered self-employed.

(a) *General.* Although we generally exclude services performed by employees from the definition of trade or business, certain types of services are considered a trade or business even though performed by employees. If you perform any of the services described in paragraphs (b) through (f) of this section, you are self-employed for social security purposes. Certain other services described in §404.1071 (relating to ministers and members of religious orders) and §404.1073 (relating to certain public officers) may be considered a trade or business even though performed by employees.

(b) *Newspaper vendors.* If you have attained age 18 and perform services as a newspaper vendor that are described in §404.1030(b), you are engaged in a trade or business.

(c) *Sharefarmers.* If you perform services as a sharefarmer that are described in §404.1017, you are engaged in a trade or business.

(d) *Employees of a foreign government, an instrumentality wholly owned by a foreign government, or an international organization.* If you are a United States citizen and perform the services that are described in §404.1032, §404.1033(a), or §404.1034(a), you are engaged in a trade or business if the services are performed in the United States and are not covered as employment based upon §404.1034(c).

(e) *Certain fishermen.* If you perform services as a fisherman that are described in §404.1031, you are engaged in a trade or business.

(f) *Employees of a church or church-controlled organization that has elected to exclude employees from coverage as employment.* If you perform services that are excluded from employment as described in §404.1026, you are engaged in a trade or business. Special rules apply to your earnings from those services which are known as church employee income. If you are paid $100 or more in a taxable year by an employer who has elected to have its employees excluded, those earnings are self-employment income (see §404.1096(c)(1)). In figuring your church employee income you may not reduce that income by any deductions attributable to your work. Your church employee income and deductions may not be taken into account in determining the amount of other net earnings from self-employment. Effective for taxable years beginning on or after January 1, 1990, your church employee income is exempt from self-employment tax under the conditions set forth for members of certain religious groups (see §404.1075).

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985; 58 FR 64889, Dec. 10, 1993; 61 FR 38367, July 24, 1996]

§ 404.1069 Real estate agents and direct sellers.

(a) *Trade or business.* If you perform services after 1982 as a qualified real estate agent or as a direct seller, as defined in section 3508 of the Code, you are considered to be engaging in a trade or business.

(b) *Who is a qualified real estate agent.* You are a qualified real estate agent as defined in section 3508 of the Code if you are a salesperson and—

(1) You are a licensed real estate agent;

(2) Substantially all of the earnings (whether or not paid in cash) for the services you perform as a real estate agent are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

(c) *Who is a direct seller.* You are a direct seller as defined in section 3508 of the Code if—

(1) You are engaged in the trade or business of selling (or soliciting the sale of) consumer products—

(i) To any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis which the Secretary of the Treasury prescribes by regulations, for resale (by the buyer or any other person) in the home or in other than a permanent retail establishment; or

(ii) In the home or in other than a permanent retail establishment; and

(2) Substantially all of your earnings (whether or not paid in cash) for the performance of these services are directly related to sales or other output (including the performance of services) rather than to the number of hours worked; and

(3) Your services are performed under a written contract between yourself and the person for whom the services are performed which provides you will not be treated as an employee with respect to these services for Federal tax purposes.

[48 FR 40515, Sept. 8, 1983]

§ 404.1070 Christian Science practitioners.

If you are a Christian Science practitioner, the services you perform in the exercise of your profession are a trade or business unless you were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with section 1704(b) of the Tax Reform Act of 1986. An exemption cannot be granted if you filed a valid waiver certificate under the provisions that apply to taxable years ending before 1968.

[55 FR 7311, Mar. 1, 1990]

§ 404.1071 Ministers and members of religious orders.

(a) If you are a duly ordained, commissioned, or licensed minister of a church, or a member of a religious order who has not taken a vow of poverty, the services you perform in the exercise of your ministry or in the exercise of duties required by the order (§ 404.1023 (c) and (e)) are a trade or business unless you filed for and were granted an exemption from coverage under section 1402(e) of the Code, and you did not revoke such exemption in accordance with section 1704(b) of the Tax Reform Act of 1986. An exemption cannot be granted if you filed a valid waiver certificate under the provisions that apply to taxable years ending before 1968.

(b) If you are a member of a religious order and have taken a vow of poverty, the services you perform in the exercise of your duties required by the order may be covered as employment. (See § 404.1023 (a) and (e)).

[45 FR 20075, Mar. 27, 1980, as amended at 55 FR 7311, Mar. 1, 1990]

§ 404.1073 Public office.

(a) *General.* The performance of the functions of a public office is not a trade or business except under the circumstances explained in paragraph (b) of this section. If you are an officer of a State or political subdivision, you are considered as employee of the State or political subdivision.

(b) *State and local governmental employees paid by fees*—(1) *Voluntary coverage under section 218 of the Act.* The

services of employees of States and political subdivisions, including those in positions paid solely on a fee-basis, may be covered as employment by a Federal-State agreement under section 218 of the Act (see subpart M of this part). States, when entering into these agreements, have the option of excluding under the agreement coverage of services in positions paid solely by fees. If you occupy a position paid solely on a fee-basis and the State has not covered your services under section 218 of the Act, you are considered to be engaged in a trade or business.

(2) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Beginning with services performed after July 1, 1991, Social Security coverage (old-age, survivors, disability, and hospital insurance) is mandatory, with certain exceptions, for services performed by employees of a State, a political subdivision of a State, or of a wholly owned instrumentality of one or more of the foregoing, if the employees are not members of a retirement system of the State, political subdivision, or instrumentality. Among the exclusions from such mandatory coverage is service performed by an employee in a position compensated solely on a fee-basis which is treated pursuant to section 211(c)(2)(E) of the Act as a trade or business for purposes of inclusion of such fees in the net earnings from self-employment.

(3) If you are a notary public, you are not a public officer even though you perform a public function. Your services as a notary public are not covered for social security purposes.

[45 FR 20075, Mar. 27, 1980, as amended at 57 FR 59910, Dec. 17, 1992]

§404.1074 Farm crew leader who is self-employed.

If you are a farm crew leader and are deemed the employer of the workers as described in §404.1010, we consider you to be engaged in a trade or business. This includes services performed in furnishing workers to perform agricultural labor for others, as well as services performed as a member of the crew.

§404.1075 Members of certain religious groups opposed to insurance.

(a) You may file an application with the Internal Revenue Service for exemption from social security self-employment tax if—

(1) You are a member of a recognized religious sect or division of the sect; and

(2) You adhere to the tenets or teachings of the sect or division of the sect and for this reason are conscientiously opposed to receiving benefits from any private or public insurance that—

(i) Makes payments in the event of death, disability, old age, or retirement; or

(ii) Makes payments toward the cost of, or provides services for, medical care (including the benefits of any insurance system established by the Act).

(b) Your application must be filed under the rules described in 26 CFR 1.1402(h). An application must contain or be accompanied by the applicant's waiver of all benefits and payments under title II and part A of title XVIII of the Act. See §404.305 for the effect of the filing of the waiver and the granting of the exemption.

(c) Regardless of whether you meet all these conditions, your application for exemption will not be approved unless we find that—

(1) The sect or division of the sect has established tenets or teachings which cause you to be conscientiously opposed to the types of insurance benefits described in paragraph (a)(2) of this section;

(2) For a substantial period of time it has been the practice for members of the sect or division of the sect to make provision for their dependent members which is reasonable in view of their general level of living; and

(3) The sect or division of the sect has been in existence continuously since December 31, 1950.

(d) Your application for exemption will be approved by the Internal Revenue Service only if no benefit or other payment under title II or part A of title XVIII of the Act became payable or, but for section 203 or section 222(b) of the Act, would have become payable, to you or on your behalf at or before

the time of the filing of your application for exemption.

(e) The tax exemption ceases to be effective for any taxable year ending after the time you do not meet the requirements of paragraph (a) of this section or after the time we find the religious sect or division of the sect of which you are a member no longer meets the requirements of paragraph (c) of this section. If your tax exemption ceases to be effective, your waiver of the right to receive Social Security and Medicare part A benefits will also no longer be effective. Benefits may be payable based upon your wages for and after the calendar year following the calendar year in which the event occurred upon which the cessation of the exemption is based. Benefits may be payable based upon your self-employment income for and after the taxable year in which the event occurred upon which the cessation of the exemption is based.

[45 FR 20075, Mar. 27, 1980, as amended at 58 FR 64890, Dec. 10, 1993]

§ 404.1077 Individuals under railroad retirement system.

If you are an employee or employee representative as defined in section 3231 (b) and (c) of the Code, your work is not a trade or business. Your services are covered under the railroad retirement system.

SELF-EMPLOYMENT INCOME

§ 404.1080 Net earnings from self-employment.

(a) *Definition of net earnings from self-employment.* If you are self-employed, you must first determine the amount of your net earnings from self-employment before figuring the amount of your earnings that count for social security purposes. Some of your earnings may not be included as net earnings from self-employment even though they are taxable for income tax purposes. If you are an employee but we consider you to be self-employed for social security purposes, you must figure your earnings as though you were actually self-employed unless you work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)). Subject to the special rules in §§ 404.1081 through 404.1095, the term *net earnings from self-employment* means—

(1) Your gross income, as figured under subtitle A of the Code, from any trade or business you carried on, less deductions attributed to your trade or business that are allowed by that subtitle; plus

(2) Your distributive share of income (or loss) from a trade or business carried on by a partnership of which you are a member, as described in paragraph (b) of this section.

(b) *Income or loss from a partnership.* (1) Your distributive share (whether or not actually distributed) of the income or loss from any trade or business carried on by a partnership of which you are a member, other than as a limited partner, is determined under section 704 of the Code.

(2) If you are a limited partner, your distributive share is included in your net earnings from self-employment if—

(i) The amount is payable to you for services you render to or on behalf of the partnerships; and

(ii) It is a guaranteed payment described in section 707(c) of the Code.

(3) You are a *limited partner* if your financial liability for the obligations of the partnership is limited to the amount of your financial investment in the partnership. Generally, you will not have to perform services in the operation of, or participate in the control of, the business carried on by the partnership for the taxable year involved.

(c) *Reporting methods.* Your gross income from a trade or business includes the gross income you received (under the cash method) or that accrued to you (under the accrual method) from the trade or business in the taxable year. It is immaterial that the income may be attributable in whole or in part to services you rendered or other acts you performed in a prior taxable year.

(d) *What is a taxable year.* (1) The term *taxable year* means—

(i) Your annual accounting period on which you regularly figure your income in keeping your books; or

(ii) A short period resulting from your death before the end of your annual accounting period or from a change of your annual accounting period.

(2) The term *annual accounting period* means—

(i) A calendar year, consisting of 12 months ending on December 31; or

(ii) A fiscal year, consisting of—

(A) 12 months ending on the last day of any month other than December; or

(B) A period, if elected under section 441 of the Code, that varies from 52 to 53 weeks and always ends on the same day of the week that occurs last in a calendar month or nearest to the last day of the calendar month.

(3) Your taxable year for figuring self-employment income is the same as your taxable year for the purposes of subtitle A of the Code. Your taxable year is a calendar year if—

(i) You keep no books;

(ii) You have no annual accounting period; or

(iii) You have an annual accounting period that differs from the definition of fiscal year as described in paragraph (d)(2)(ii) of this section.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§404.1081 General rules for figuring net earnings from self-employment.

(a) *Determining net earnings.* (1) In determining your gross income and the deductions attributable to your trade or business for the purpose of determining your net earnings from self-employment, the provisions that apply to the taxes imposed by sections 1 and 3 of the Code are used.

(2) If you use the accrual method of accounting to figure your taxable income from a trade or business, you must use the same method in determining your net earnings from self-employment.

(3) If you are engaged in a trade or business of selling property on the installment plan and elect, under the provisions of section 453 of the Code, to use the installment method of accounting in figuring your income, you must use the installment method in determining your net earnings from self-employment.

(4) Any income which can be excluded from gross income under any provision of subtitle A of the Code cannot be counted in determining your net earnings from self-employment, unless—

(i) You are a resident of Puerto Rico (see §404.1089);

(ii) You are a minister or member of a religious order (see §404.1091);

(iii) You are a United States citizen or resident engaged in a trade or business outside the United States (see §404.1092); or

(iv) You are a citizen of, or have income from sources within, certain possessions of the United States (see §404.1093).

(b) *Trade or business carried on.* You must carry on the trade or business either personally or through agents or employees. Income from a trade or business carried on by an estate or trust is not included in determining the net earnings from self-employment of the individual beneficiaries of the estate or trust.

(c) *Aggregate net earnings.* If you are engaged in more than one trade or business, your net earnings from self-employment consist of the total of the net income and losses of all the trades or businesses you carry on. A loss in one trade or business you carry on offsets the income from another trade or business.

(d) *Partnerships.* When you have net earnings from self-employment from a partnership as described in §404.1080 (a) and (b), those net earnings are combined with your other net earnings from self-employment in determining your total net earnings from self-employment for the taxable year.

(e) *Different taxable years.* If you are a partner and your taxable year is different from that of the partnership, you must include, in figuring your net earnings from self-employment, your distributive share of the income or loss of the partnership for its taxable year ending with or within your taxable year. For the special rule in case of the termination of a partner's taxable year as a result of death, see §404.1087.

(f) *Meaning of partnerships.* A partnership for social security purposes is one that is recognized as a partnership for income tax purposes. For income tax purposes, the term *partnership* includes not only a partnership as known under common law, but also a syndicate, group, pool, joint venture, or other unincorporated organization that carries

on any trade or business, financial operation, or venture, and which is not a trust, estate, or a corporation.

(g) *Proprietorship taxed as domestic corporation.* If you are a proprietor of an unincorporated business enterprise and have elected to be taxed as a domestic corporation, you must figure your net earnings from self-employment without regard to the election you have made.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1082 Rentals from real estate; material participation.

(a) *In general.* Your rentals from real estate and from personal property leased with the real estate (including rentals paid in crop shares) and the deductions attributable to the rentals are excluded in figuring your net earnings from self-employment, unless you receive the rentals in the course of a trade or business as a real estate dealer. If you are an owner or lessee of land, rentals paid in crop shares include income you get under an agreement with another person if the arrangement provides for the following:

(1) The other person will produce agricultural or horticultural commodities on the land.

(2) The commodities produced, or the income from their sale, will be divided between you and the other person.

(3) The amount of your share depends on the amount of the commodities produced.

(b) *Real estate dealers.* (1) You are a real estate dealer if you are engaged in the business of selling real estate to customers for profit.

(2) If you merely hold real estate for investment or speculation and receive rental income from it, you are not considered a real estate dealer.

(3) If you are a real estate dealer, but also hold real estate for investment or speculation in addition to real estate you hold for sale to customers, only the rental income from the real estate held for sale to customers and the deductions attributable to it are included in determining your net earnings from self-employment. The rental income from real estate you hold for investment or speculation and the deductions attributable to it are not counted in figuring your net earnings from self-employment.

(c) *Special rule for farm rental income*—(1) *In general.* If you own or lease land, any income you derive from it is included in figuring your net earnings from self-employment if—

(i) The income results from an arrangement between you and another person which provides for the other person to produce agricultural or horticultural commodities on the land that you own or lease and for you to materially participate in the production or the management of the production of the agricultural or horticultural commodities; and

(ii) You actually do materially participate.

(2) *Nature of arrangement.* (i) The arrangement between you and the other person may be either oral or written. It must provide that the other person will produce one or more agricultural or horticultural commodities and that you will materially participate in the production or the management of the production of the commodities.

(ii) The term *production,* refers to the physical work performed and the expenses incurred in producing a commodity. It includes activities like the actual work of planting, cultivating, and harvesting crops, and the furnishing of machinery, implements, seed, and livestock.

(iii) The term *management of the production,* refers to services performed in making managerial decisions about the production of the crop, such as when to plant, cultivate, dust, spray, or harvest, and includes advising and consulting, making inspections, and making decisions on matters, such as rotation of crops, the type of crops to be grown, the type of livestock to be raised, and the type of machinery and implements to be furnished.

(3) *Material participation.* (i) If you show that you periodically advise or consult with the other person, who under the rental arrangement produces the agricultural or horticultural commodities, and also show that you periodically inspect the production activities on the land, you will have presented strong evidence that you are materially participating.

(ii) If you also show that you furnish a large portion of the machinery, tools, and livestock used in the production of the commodities, or that you furnish or advance monies, or assume financial responsibility, for a substantial part of the expense involved in the production of the commodities, you will have established that you are materially participating.

(4) *Employees or agents.* We consider any farm rental arrangement entered into by your employee or agent and another person to be an arrangement entered into by you. However, we do not consider the services of an employee or agent as your services in determining the extent to which you have participated in the production or management of production of a commodity.

(5) *Examples.*

Example 1. After the death of her husband, Ms. A rents her farm, together with its machinery and equipment, to B for one-half of the proceeds from the commodities produced on the farm by B. It is agreed that B will live in the tenant house on the farm and be responsible for the overall operation of the farm, such as planting, cultivating, and harvesting the field crops, caring for the orchard and harvesting the fruit and caring for the livestock and poultry. It also is agreed that Ms. A will continue to live in the farm residence and help B operate the farm. Under the agreement it is expected that Ms. A will regularly operate and clean the cream separator and feed the poultry flock and collect the eggs. When possible she will assist B in such work as spraying the fruit trees, penning livestock, culling the poultry, and controlling weeds. She will also assist in preparing the meals when B engages seasonal workers. The agreement between Ms. A and B clearly provides that she will materially participate in the overall production operations to be conducted on her farm by B. In actual practice, Ms. A regularly performs those services. The regularly performed services are material to the production of an agricultural commodity, and the services performed are material to the production operations to which they relate. The furnishing of a substantial portion of the farm machinery and equipment also supports the conclusion that Ms. A has materially participated. Accordingly, the rental income Ms. A receives from her farm should be included in her net earnings from self-employment.

Example 2. G owns a fully-equipped farm which he rents to H under an arrangement which provides that G will materially participate in the management of the production of crops raised on the farm under the arrangement. G lives in town about 5 miles from the farm. About twice a month he visits the farm and looks over the buildings and equipment. G may occasionally, in an emergency, discuss with H some phase of a crop production activity. In effect, H has complete charge of the management of farming operations regardless of the understanding between him and G. Although G pays one-half of the cost of the seed and fertilizer and is charged for the cost of materials purchased by H to make all necessary repairs, G's activities are not material in the crop production activities. Accordingly, G's income from the crops is not included in net earnings from self-employment.

(d) *Rental income from living quarters*—(1) *No services provided for occupants.* Payments you receive for renting living quarters in a private residence, duplex, or multiple-housing unit are generally rental income from real estate. Except in the case of real estate dealers, these payments are excluded in determining net earnings from self-employment, even if the payments are in part attributable to personal property furnished under the lease.

(2) *Services provided for occupants.* (i) Payments you receive for renting living quarters where services are also provided to the occupant, as in hotels, boarding houses, or apartment houses furnishing hotel services, or in tourist camps or tourist homes, are included in determining your net earnings from self-employment. Any payments you receive for the use of space in parking lots, warehouses, or storage garages are also included in determining your net earnings from self-employment.

(ii) Generally, we consider services to be provided to the occupant if they are primarily for the occupant's convenience and are other than those usually provided in connection with the rental of rooms or other space for occupancy only. We consider the supplying of maid service to be a service provided to the occupant. However, we do not consider the furnishing of heat and light, the cleaning of public entrances, exits, stairways, and lobbies and the collection of trash, as services provided to the occupant.

Example: A owns a building containing four apartments. During the taxable year, A received $1,400 from apartments numbered 1 and 2, which are rented without services provided to the occupants, and $3,600 from apartments numbered 3 and 4, which are

rented with services provided. A's fixed expenses for the four apartments are $1,200 during the taxable year. In addition, A has $500 of expenses attributable to the services provided to the occupants of apartments 3 and 4. In determining his net earnings from self-employment, A includes the $3,600 received from apartments 3 and 4, and the expenses of $1,100 ($500 plus one-half of $1,200) attributable to them. The rentals and expenses attributable to apartments 1 and 2 are excluded. Therefore, A has $2,500 of net earnings from self-employment from the building for the taxable year.

(e) *Treatment of business income which includes rentals from real estate.* If an individual or a partnership is engaged in a trade or business other than real estate, and part of the income is rentals from real estate, only that part of the income which is not rentals and the expenses attributable to that portion are included in determining net earnings from self-employment.

§ 404.1083 Dividends and interest.

(a) The dividends you receive on shares of stock are excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the dividends in the course of your trade or business.

(b) The interest you receive on a bond, debenture, note, certificate, or other evidence of indebtedness issued with interest coupons or in registered form by any corporation (including one issued by a government or political subdivision) is excluded in determining your net earnings from self-employment, unless you are a dealer in stocks and securities and receive the interest in the course of your trade or business.

(c) If you hold stocks or securities for investment or speculation purposes, any dividends and interest you receive that are excludable under paragraphs (a) and (b) of this section are excluded in determining your net earnings from self-employment, whether or not you are a dealer in stocks and securities.

(d) A dealer in stocks or securities is a merchant with an established place of business who is regularly engaged in the business of purchasing stocks or securities and reselling them to customers. The dealer, as a merchant, buys stocks or securities and sells them to customers with a view to making a profit. Persons who buy and sell or hold stocks or securities for investment or speculation, regardless of whether the buying or selling constitutes a trade or business, are not dealers in stocks or securities.

[45 FR 20075, Mar. 25, 1980; 45 FR 25060, Apr. 14, 1980]

§ 404.1084 Gain or loss from disposition of property; capital assets; timber, coal, and iron ore; involuntary conversion.

(a) If you are engaged in a trade or business, you must, in determining your net earnings from self-employment, exclude any gain or loss—

(1) That is considered a gain or loss from the sale or exchange of a capital asset;

(2) From the cutting of timber or from the disposal of timber or coal, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss;

(3) From the disposal of iron ore mined in the United States, even if held primarily for sale to customers, if section 631 of the Code applies to the gain or loss; and

(4) From the sale, exchange, involuntary conversion, or other disposition of property that is not—

(i) Stock in trade or other property of a kind which would properly be included in inventory if on hand at the close of the taxable year; or

(ii) Property held primarily for sale to customers in the ordinary course of a trade or business;

(b) For purposes of paragraph (a)(4) of this section, it is immaterial whether a gain or loss is treated as a capital gain or as an ordinary gain or loss for purposes other than determining earnings from self-employment.

(c) For purposes of paragraph (a)(4) of this section—

(1) The term *involuntary conversion* means a compulsory or unintended change of property into other property or money as a result of such things as destruction, theft or seizure; and

(2) The term *other disposition* includes destruction or loss by fire, theft, storm, shipwreck, or other casualty, even though there is no change of the property into other property or money.

Example: During the taxable year 1976, A, who owns a grocery store, had a net profit of $1,500 from the sale of groceries and a gain of $350 from the sale of a refrigerator case. During the same year, he had a loss of $2,000 as a result of damage by fire to the store building. In figuring taxable income for income tax purposes, all of these items are considered. In determining net earnings from self-employment, however, only the $1,500 of profit derived from the sale of groceries is included. The $350 gain and the $2,000 loss are excluded.

§ 404.1085 Net operating loss deduction.

When determining your net earnings from self-employment, you disregard the deduction provided by section 172 of the Code that relates to net operating losses sustained in years other than the taxable year.

§ 404.1086 Community income.

(a) *In case of an individual.* (1) If community property laws apply to income that an individual derives from a trade or business (other than a trade or business carried on by a partnership), all of the gross income and the deductions attributable to the income are generally treated as the gross income and deductions of the husband. However, if the wife exercises substantially all of the management and control of that trade or business, all of the gross income and deductions are treated as the gross income and deductions of the wife.

(2) The term *management and control* means management and control in fact, not the management and control given to the husband under the community property laws. For example, a wife who operates a beauty parlor without any significant help from her husband will be considered as having substantially all of the management and control of the business, despite the provision of any community property law giving the husband the right of management and control of community property. The income and deductions from the operations of the beauty parlor are considered the income and deductions of the wife.

(b) *In case of a partnership.* Even though only a portion of a partner's distributive share of the income or loss from a trade or business carried on by a partnership is community income or loss under the community property laws applicable to the share, all of the distributive share is included in figuring the net earnings from self-employment of that partner. No part of the share is taken into account in figuring the net earnings from self-employment of the spouse of the partner. In any case in which both spouses are members of the same partnership, the distributive share of the income or loss of each spouse is included in figuring the net earnings from self-employment of that spouse.

§ 404.1087 Figuring partner's net earnings from self-employment for taxable year which ends as a result of death.

(a) *General.* In the case of a deceased partner whose taxable year ends because of death, the deceased partner's net earnings from self-employment includes the amount of his or her distributive share of partnership ordinary income or loss for the partnership's taxable year that is attributable to an interest in the partnership through the month of death.

(b) *Computation.* (1) The deceased partner's distributive share of partnership ordinary income or loss for the partnership taxable year in which death occurred is determined by applying the rules contained in paragraphs (d) and (f) of § 404.1081.

(2) The portion of the distributive share to be included in the deceased partner's net earnings from self-employment for his or her last taxable year is determined by treating the ordinary income or loss constituting the distributive share as having been realized or sustained ratably over the partnership taxable year during which the deceased partner had an interest in the partnership and during which the deceased partner's estate, or any other person succeeding by reason of the death to rights to his partnership interest, held an interest in the partnership.

(c) *Deceased partner's distributive share.* A deceased partner's distributive share includes the distributive share of the estate or of any other person succeeding to the interest of a deceased partner. It does not include any share attributable to a partnership interest

that was not held by the deceased partner at the time of death. If a deceased partner's estate should acquire an interest in a partnership in addition to the interest to which it succeeded upon the death of the deceased partner, the amount of the distributive share attributable to the additional interest acquired by the estate is not included in computing the deceased partner's distributive share of the partnership's ordinary income or loss for the partnership taxable year.

(d) *Options available to farmers.* In determining the applicability of the optional method of figuring net earnings from self-employment to a member of a farm partnership it is necessary to determine the partner's distributive share of partnership gross income or distributive share of income described in section 702(a)(8) of the Code.

§ 404.1088 Retirement payment to retired partners.

(a) *In general.* If you are a retired partner, in figuring your net earnings from self-employment you must exclude payments made to you on a periodic basis by a partnershp on account of your retirement and which are to continue until your death. This exclusion applies only if the payments are made under a written plan which meets the requirements set out in 26 CFR 1.1402(a)–(17) and the conditions in paragraph (b) of this section are met. The necessary requirements and conditions must be met throughout the entire partnership's taxable year for the payments to be excluded so that either all or none of the payments are excluded.

(b) *Other conditions.* You must have been paid your full share of the partnership's capital before the close of the partnership's taxable year in which retirement payments are made. Also, no member of the partnership can have any financial obligations to you (in his or her capacity as a partner) except to make the retirement payments. Lastly, you cannot perform any services for the partnership in the partnership's taxable year which falls wholly or partially in your taxable year in which you receive the retirement payments.

Example: D, a partner in the DEF partnership, retired from the partnership as of December 31, 1976. The taxable year of both D and the partnership is the calendar year. During the partnership's taxable year ending December 31, 1977, D rendered no service to any trade or business carried on by the partnership. On or before December 31, 1977, all obligations (other than retirement payments under the plan) from the other partners to D were liquidated, and D's share of the capital of the partnership was paid to him. Retirement payments received by D under the partnership's plan in his taxable year ending December 31, 1977, are excluded in determining net earnings from self-employment (if any) for that taxable year.

§ 404.1089 Figuring net earnings for residents and nonresidents of Puerto Rico.

(a) *Residents.* If you are a resident of Puerto Rico, whether or not you are an alien, a citizen of the United States, or a citizen of Puerto Rico, you must figure your net earnings from self-employment in the same manner as would a citizen of the United States residing in the United States. In figuring your net earnings from self-employment you must include your income from sources in Puerto Rico even though you are a resident of Puerto Rico during the entire taxable year.

(b) *Nonresidents.* A citizen of Puerto Rico, who is also a citizen of the United States and who is not a resident of Puerto Rico must figure net earnings from self-employment in the same manner as other citizens of the United States.

§ 404.1090 Personal exemption deduction.

The deduction provided by section 151 of the Code, relating to personal exemptions, is excluded in determining net earnings from self-employment.

§ 404.1091 Figuring net earnings for ministers and members of religious orders.

(a) *General.* If you are a duly ordained, commissioned, or licensed minister of a church or a member of a religious order who has not taken a vow of poverty, we consider you to be engaged in a trade or business under the conditions described in § 404.1071 with regard to services described in § 404.1023 (c) and (e). In figuring your net earnings from self-employment from performing

these services, you must include certain income (described in paragraphs (b) and (c) of this section) that may be excluded from your gross income for income tax purposes.

(b) *Housing and meals.* You must include in figuring your net earnings from self-employment the rental value of a home furnished to you and any rental allowance paid to you as payment for services performed in the exercise of your ministry or in the exercise of duties required by your order even though the rental value or rental allowance may be excluded from gross income by section 107 of the Code. Also, the value of any meals or lodging furnished to you in connection with the performance of these services is included in figuring your net earnings from self-employment even though their value is excluded from gross income by section 119 of the Code.

(c) *Services outside the United States.* If you one are a citizen or resident of the United States performing services outside the United States which are in the exercise of your ministry or in the exercise of duties required by your order, your net earnings from self-employment from the performance of these services are figured as described in paragraph (b) of this section. However, they are figured without regard to the exclusions from gross income provided in sections 911 and 931 of the Code relating to earned income from services performed outside the United States and from sources within possessions of the United States.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36574, Sept. 9, 1985]

§ 404.1092 Figuring net earnings for U.S. citizens or residents living outside the United States.

(a) *Taxable years beginning after December 31, 1983.* If you are a citizen or resident of the United States and are engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911 (a)(1) of the Code.

(b) *Taxable years beginning after December 31, 1981, and before January 1, 1984.* If you are a citizen of the United States and were engaged in a trade or business outside the United States, your net earnings from self-employment are figured without regard to the exclusion from gross income provided by section 911(a)(1) of the Code unless you are a resident of a foreign country or countries for an uninterrupted period which includes an entire taxable year.

[50 FR 36574, Sept. 9, 1985]

§ 404.1093 Possession of the United States.

In using the exclusions from gross income provided under section 931 of the Code (relating to income from sources within possessions of the United States) and section 932 of the Code (relating to citizens of possessions of the United States) for purposes of figuring your net earnings from self-employment, the term *possession of the United States* shall be deemed not to include the Virgin Islands, Guam, or American Samoa.

§ 404.1094 Options available for figuring net earnings from self-employment.

(a) *General.* If you have income from a trade or business in certain situations, you have options for figuring your net earnings from self-employment. The options available to you depend on whether you have income from an agricultural trade or business or a non-agricultural trade or business. For a definition of agricultural trade or business see § 404.1095.

(b) *Agricultural trade or business.* The net earnings from self-employment you derive from an agricultural trade or business may, at your option, be figured as follows:

(1) *Gross income of $2,400 or less.* If your gross income is $2,400 or less you may, at your option, report 66⅔ percent of the gross income as net earnings from self-employment instead of your actual net earnings from your business.

(2) *Gross income of more than $2,400.* If your gross income is more than $2,400 and your actual net earnings from your business are less than $1,600 you may, at your option, report $1,600 as net earnings from self-employment instead

of your actual net earnings. If your actual net earnings are $1,600 or more you cannot use the optional method.

(3) *Two or more agricultural trades or businesses.* If you carry on more than one agricultural trade or business as a sole proprietor or as a partner, you must combine your gross income and net income from each trade or business to find out whether you may use the optional method of figuring net earnings.

(c) *Non-agricultural trade or business.* (1) The net earnings from self-employment you derive from a non-agricultural trade or business may be reported under an optional method if you are self-employed on a regular basis (as defined in paragraph (c)(4) of this section). You cannot use the optional method of reporting for more than 5 taxable years, and you cannot report less than your actual net earnings from self-employment.

(2) *Computation.* If your actual net earnings from self-employment are less than $1,600 and less than 66⅔ percent of your gross income, you may, at your option, report 66⅔ percent of your gross income (but not more than $1,600) as your net earnings from self-employment.

Example: A operates a grocery store and files income tax returns on a calendar year basis. A meets the *self-employed on a regular basis* requirement because actual net earnings from self-employment were $400 or more in 1976 and in 1977. Gross income and net profit from operating the grocery store in 1978 through 1980 are as follows:

	1978	1979	1980
Gross income	$2,800	$1,200	$1,000
Net profit	300	400	800

For the year 1978, A may report as annual net earnings from self-employment either—

(i) None. (Actual net earnings from self-employment are less than $400); or

(ii) $1,600. (Non-agricultural option, 66⅔ percent of $2,800, but not to exceed the $1,600 maximum.)

For the year 1979, A may report as annual net earnings from self-employment either—

(i) $400. (Actual net earnings from self-employment); or

(ii) $800. (Non-agricultural option, 66⅔ percent of $1,200.)

For the year 1980, A must report $800, the actual net earnings from self-employment. The non-agricultural option is not available because A's actual net earnings are not less than 66⅔ percent of the gross income.

(3) *Figuring net earnings from both non-agricultural and agricultural self-employment.* If you are self-employed on a regular basis, you may use the non-agricultural optional method of reporting when you have both non-agricultural and agricultural trades or businesses. However, in order to use this method, your actual net earnings from non-agricultural self-employment combined with your actual net earnings from agricultural self-employment, or your optional net earnings from agricultural self-employment, must be less than $1,600, and the net non-agricultural earnings must be less than 66⅔ percent of your gross non-agricultural income. If you qualify for using both the non-agricultural and agricultural option, you may report less than your actual total net earnings, but not less than your actual net earnings from non-agricultural self-employment alone. If you elect to use both options in a given taxable year, the combined maximum reportable net earnings from self-employment may not exceed $1,600.

Example: C was regularly self-employed. She derived actual net earnings from self-employment of $400 or more in 1975 and in 1976. Her gross income and net profit from operating both a grocery store and a farm in 1978 are:

GROCERY STORE	
Gross income	$1,000
Net profit	800
FARM	
Gross income	$2,600
Net profit	400

For the year 1978, C may report $1,200 (actual net earnings from self-employment from both businesses), or $2,400 ($1,600 agricultural option (66⅔ percent of $2,600 farm gross income not to exceed $1,600) and $800 grocery store profit). C cannot use the non-agricultural option for 1978 because her actual grocery store net exceeds 66⅔ percent of her grocery store gross income.

(4) *Self-employed on a regular basis.* For any taxable year beginning after 1972, we consider you to be self-employed on a regular basis, or to be a member of a partnership on a regular basis, if, in at least 2 of the 3 taxable years immediately before that taxable year, you had actual net earnings from self-employment of not less than $400 from agricultural and non-agricultural

trades or businesses (including your distributive share of the net income or loss from any partnership of which you are a member).

(d) *Members of partnerships.* If you are a member of a partnership you may use the optional method of reporting. Your gross income is your distributive share of the partnership's gross income (after all guaranteed payments to which section 707(c) of the Code applies have been deducted), plus your own guaranteed payment.

(e) *Computing gross income.* For purposes of this section gross income means—

(1) Under the cash method of computing, the gross receipts from the trade or business reduced by the cost or other basis of property that was purchased and sold, minus any income that is excluded in computing net earnings from self-employment; or

(2) Under the accrual method of computing, the gross income minus any income that is excluded in figuring net earnings from self-employment.

(f) *Exercise of option.* For each taxable year for which you are eligible to use the optional method and elect to use that method, you must figure your net earnings from self-employment in that manner on your tax return for that year. If you wish to change your method of reporting after your tax return is filed, you may change it by filing an amended tax return with the Internal Revenue Service or by filing with us Form 2190, Change in Method of Computing Net Earnings from Self-Employment.

§404.1095 Agricultural trade or business.

(a) An agricultural trade or business is one in which, if the trade or business were carried on entirely by employees, the major portion of the services would be agricultural labor (§404.1057).

(b)(1) If the services are partly agricultural and partly non-agricultural, the time devoted to the performance of each type of service is the test used to determine whether the major portion of the services is agricultural labor.

(2) If more than half of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is agricultural.

(3) If half or less of the time spent in performing all the services is spent in performing services that are agricultural labor, the trade or business is not agricultural. The time spent in performing the services is figured by adding the time spent in the trade or business during the taxable year by every individual (including the individual carrying on the trade or business and the members of that individual's family).

(c) We do not apply the rules in this section if the non-agricultural services are performed in connection with a trade or business separate and distinct from the agricultural trade or business. A roadside automobile service station on a farm is a trade or business separate and distinct from the agricultural trade or business, and the gross income from the service station, less the deductions attributable to it, is to be considered in determining net earnings from self-employment.

(d) We consider a sharefarmer (see §404.1068(c)) or a materially participating owner or tenant (see §404.1082(c)) to be engaged in an agricultural trade or business. We use the rules in this section to determine whether a farm crew leader who is self-employed (see §404.1074) is engaged in an agricultural trade or business.

§404.1096 Self-employment income.

(a) *General.* Self-employment income is the amount of your net earnings from self-employment that is subject to social security tax and counted for social security benefit purposes. The term *self-employment income* means the net earnings from self-employment you derive in a taxable year, except as described in paragraphs (b), (c) and (d) of this section.

(b) *Maximum self-employment income.* (1) The term *self-employment income* does not include that part of your net earnings from self-employment that exceeds (or that part of your net earnings from self-employment which, when added to the wages you received in that taxable year, exceeds)—

Taxable year	Amount
Ending before 1955	$3,600

Taxable year	Amount
Ending in 1955 through 1958	4,200
Ending in 1959 through 1965	4,800
Ending in 1966 and 1967	6,600
Ending after 1967 and beginning before 1972	7,800
Beginning in 1972	9,000
Beginning in 1973	10,800
Beginning in 1974	13,200
Beginning in 1975	14,100
Beginning in 1976	15,300
Beginning in 1977	16,500
Beginning in 1978	17,700
Beginning in 1979	22,900
Beginning in 1980	25,900
Beginning in 1981	29,700
Beginning in 1982	32,400
Beginning in 1983	35,700
Beginning in 1984	37,800
Beginning in 1985	39,600
Beginning in 1986	42,000
Beginning in 1987	43,800
Beginning in 1988	45,000
Beginning in 1989	48,000
Beginning in 1990	51,300
Beginning in 1991	53,400
Beginning in 1992	55,500

(2) For the purpose of this paragraph the term *wages* includes remuneration paid to an employee for services covered by an agreement entered into under section 218 of the Act, or an agreement entered into under section 3121(l) of the Code, which would be wages under section 209 of Act if the services were considered employment under section 210(a) of the Act.

(c) *Minimum net earnings from self employment.* (1) Self-employment income does not include your net earnings from self-employment when the amount of those earnings for the taxable year is less than $400. If you have only $300 of net earnings from self-employment for the taxable year you would not have any self-employment income. (Special rules apply if you are paid $100 or more and work for a church or church-controlled organization that has exempted its employees (see § 404.1068(f)).)

(2) If you have net earnings from self–employment of $400 or more for the taxable year you may have less than $400 of creditable self–employment income. This occurs where your net earnings from self–employment is $400 or more for a taxable year and the amount of your net earnings from self–employment plus the amount of the wages paid to you during that taxable year exceed the maximum creditable earnings for a year. For example, if you had net earnings from self–employment of $1,000 for 1978, and were also paid wages of $17,500 during 1978, your creditable self–employment income for 1978 would be $200.

(d) *Nonresident aliens.* A nonresident alien has self-employment income only if coverage is provided under a totalization agreement [see § 404.1913]. We do not consider an individual who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam or American Samoa to be a nonresident alien.

[45 FR 20075, Mar. 27, 1980, as amended at 50 FR 36575, Sept. 9, 1985; 52 FR 8250, Mar. 17, 1987; 57 FR 44098, Sept. 24, 1992]

Subpart L [Reserved]

Subpart M—Coverage of Employees of State and Local Governments

AUTHORITY: Secs. 205, 210, 218, and 702(a)(5) of the Social Security Act (42 U.S.C. 405, 410, 418, and 902(a)(5)); sec. 12110, Pub. L. 99–272, 100 Stat. 287 (42 U.S.C. 418 note); sec. 9002, Pub. L. 99–509, 100 Stat. 1970.

SOURCE: 53 FR 32976, Aug. 29, 1988, unless otherwise noted.

GENERAL

§ 404.1200 General.

(a) *Coverage under section 218 of the Act.* Under section 218 of the Social Security Act (the Act) a State may ask the Commissioner of Social Security to enter into an agreement to extend Federal old-age, survivors, disability and hospital insurance coverage to groups of employees of the State and its political subdivisions. The Commissioner shall enter into such an agreement. State and local government employees, after being covered under an agreement, have the same benefit rights and responsibilities as other employees who are mandatorily covered under the programs. For payments due on wages paid before 1987, the State assumes full financial and reporting responsibility for all groups covered under its agreement. The agreement may not be terminated in its entirety or with respect to any coverage group under that agreement. For payments due on wages paid in the year 1987 and years later,

section 9002 of Pub. L. 99–509 amends section 218 of the Act by transferring responsibility for collecting contributions due and receiving wage reports from the Social Security Administration (SSA) to the Internal Revenue Service (IRS). Sections of the regulations wholly or partly affected by this amendment to the Act are appended with the phrase ''—for wages paid prior to 1987.''

(b) *Mandatory old-age, survivors, disability, and hospital insurance coverage.* Under section 210(a)(7)(F) of the Act, mandatory old-age, survivors, disability, and hospital insurance coverage is extended to certain services performed after July 1, 1991, by individuals who are employees of a State (other than the District of Columbia, Guam, or American Samoa), a political subdivision of the State, or any wholly owned instrumentality of one or more of the foregoing, and who are not members of the employer's retirement system. Certain services are excluded from such mandatory coverage (see § 404.1020(a)(3).

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992; 62 FR 38450, July 18, 1997]

§ 404.1201 Scope of this subpart regarding coverage and wage reports and adjustments.

This subpart contains the rules of SSA about:

(a) Coverage under section 218 of the Act—

(1) How a State enters into and modifies an agreement; and

(2) What groups of employees a State can cover by agreement.

(b) Contributions, wage reports, and adjustments—for wages paid prior to 1987—

(1) How a State must identify covered employees and what records it must keep on those employees;

(2) Periodic reviews of the source records kept on covered employees;

(3) How and when a State must report wages and pay contributions;

(4) What the State's liability for contributions is and how SSA figures the amount of those contributions;

(5) What happens if a State fails to pay its contributions timely;

(6) How errors in reports and contribution payments are corrected;

(7) How overpayments of contributions are credited or refunded;

(8) How assessments are made if contributions are underpaid; and

(9) How a State can obtain administrative or judicial review of a decision on a credit, refund, or assessment.

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992; 65 FR 16813, Mar. 30, 2000]

§ 404.1202 Definitions.

(a) Terms which have special meaning in this subpart are described in this section. Where necessary, further explanation is included in the section where the term is used.

(b) *Coverage terms:*

Agreement—The agreement between the Commissioner of Social Security and the State containing the conditions under which retirement, survivors, disability and hospital insurance coverage is provided for State and local government employees.

Coverage—The extension of Social Security protection (retirement, survivors, disability, and hospital insurance) by agreement between the Commissioner of Social Security and a State to employees of the State and its political subdivisions or by agreement between the Commissioner of Social Security and an interstate instrumentality to employees of the interstate instrumentality.

Coverage group—The grouping by which employees are covered under an agreement.

Employee—An employee as defined in section 210(j) of the Act. Usually, the common-law control test is used in determining whether an employer-employee relationship exists. The term also includes an officer of a State or political subdivision.

Governmental function—The traditional functions of government: legislative, executive, and judicial.

Interstate instrumentality—An independent legal entity organized by two or more States to carry out one or more functions. For Social Security coverage purposes under section 218 of the Act, an interstate instrumentality is treated, to the extent practicable, as a ''State.''

Modification—A change to the agreement between the Commissioner of Social Security and a State which provides coverage of the services of employees not previously covered or which alters the agreement in some other respect.

Political subdivision—A separate legal entity of a State which usually has specific governmental functions. The term ordinarily includes a county, city, town, village, or school district, and in many States, a sanitation, utility, reclamation, drainage, flood control, or similar district. A political subdivision includes an instrumentality of a State, one or more politicial subdivisions of a State, or a State and one or more of its political subdivisions.

Proprietary function—A business engaged in by a State or political subdivision such as a public amusement park or public parking lot.

Retirement system—A pension, annuity, retirement, or similar fund or system established by a State or political subdivision.

SSA—The Social Security Administration.

State—Includes the fifty States, Puerto Rico, and the Virgin Islands. It does not include the District of Columbia, Guam or American Samoa. ''State'' also refers to an interstate instrumentality where applicable.

We—The Social Security Administration.

(c) *Contributions, wage reporting, and adjustment terms—for wages paid prior to 1987:*

Allowance of a credit or refund—The written notice to a State of the determination by SSA of the amount owed to the State by SSA, the period involved, and the basis for the determination.

Assessment—The written notice to a State of the determination by SSA of the amount (contributions or accrued interest) owed to SSA by the State, the period involved, and the basis for the determination.

Contributions—Payments made under an agreement which the State deposits in a Federal Reserve bank. The amounts are based on the wages paid to employees whose services are covered under an agreement. These amounts are equal to the taxes imposed under the Internal Revenue Code on emp1oyers and employees in private employment.

Contribution return—Form used to identify and account for all contributions actions.

Disallowance of a State's claim for credit or refund—The written notice to a State of the determination by SSA that the State's claim for credit or refund is denied, the period involved, and the basis for the determination.

Overpayment—A payment of more than the correct amount of contributions or interest.

Underpayment—A payment of less than the correct amount of contributions or interest.

Wage Reports—Forms used to identify employees who were paid wages for covered employment and the amounts of those wages paid. This includes corrective reports.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38450, July 18, 1997

§ 404.1203 Evidence—for wages paid prior to 1987.

(a) *State's responsibility for submitting evidence.* The State, under the provisions of the agreement, is responsible for accurately reporting the wages paid employees for services covered by the agreement and for paying the correct amount of contributions due on those wages. This responsibility includes submitting evidence to verify the accuracy of the reports and payments.

(b) *Failure to submit requested evidence.* The State is required to submit information timely to SSA. If we request additional evidence to verify the accuracy of reports and payments, we specify when that evidence must be submitted. If we do not receive the evidence timely, and the State provides no satisfactory explanation for its failure to submit the evidence timely, we may proceed, if appropriate, on the basis of the information we have. Proceeding on the basis of the information we have permits us to credit the wage records of employees properly, where possible, while continuing to work with the State to resolve remaining discrepancies.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1203 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1204 Designating officials to act on behalf of the State.

(a) Each State which enters into an agreement shall designate the official or officials authorized to act on the State's behalf in administering the agreement. Each State shall inform SSA of the name, title, and address of the designated official(s) and the extent of each official's authority. For example, a State may indicate that the State official is authorized:

(1) To enter into an agreement and execute modifications to the agreement; and

(2) To carry out the ministerial duties necessary to administer the agreement.

For wages paid prior to 1987:

(3) To enter into agreements to extend or re-extend the time limit for assessment or credit;

(4) To make arrangements in connection with onsite reviews; and

(5) To request administrative review of an assessment, an allowance of a credit or refund, or a disallowance of a credit or refund.

(b) Each State shall inform SSA timely of changes in designated officials or changes in their authority.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1204 was revised, effective Aug. 29, 1988 with the exception of paragraphs (a)(5) and (b). Section 404.1204 (a)(5) and (b) contain reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

WHAT GROUPS OF EMPLOYEES MAY BE COVERED

§404.1205 Absolute coverage groups.

(a) *General.* An absolute coverage group is a permanent grouping of employees, e.g., all the employees of a city or town. It is a coverage group for coverage and reporting purposes. When used for coverage purposes, the term refers to groups of employees whose positions are not under a retirement system. An absolute coverage group may include positions which were formerly under a retirement system and, at the State's option, employees who are in positions under a retirement system but who are ineligible (see §404.1208) to become members of that system.

(b) *What an absolute coverage group consists of.* An absolute coverage group consists of one of the following employee groups:

(1) State employees performing services in connection with the State's governmental functions;

(2) State employees performing services in connection with a single proprietary function of the State;

(3) Employees of a State's political subdivision performing services in connection with that subdivision's governmental functions;

(4) Employees of a State's political subdivision performing services in connection with a single proprietary function of the subdivision;

(5) Civilian employees of a State's National Guard units; and

(6) Individuals employed under an agreement between a State and the U.S. Department of Agriculture as agricultural products inspectors.

(c) *Designated coverage groups.* A State may provide coverage for designated (i.e., selected) absolute coverage groups of the State or a political subdivision. When coverage is extended to these designated groups, the State must specifically identify each group as a designated absolute coverage group and furnish the effective date of coverage and any optional exclusion(s) for each group. Where a State has provided coverage to designated absolute coverage groups, the State may, by modifying its agreement, extend that coverage to any absolute coverage group in the State.

§404.1206 Retirement system coverage groups.

(a) *General.* Section 218(d) of the Act authorizes coverage of services of employees in positions under a retirement system. For purposes of obtaining coverage, a system may be considered a separate retirement system authorized by sections 218(d)(6) (A) or (B) or 218(l) of the Act. Under these sections of the Act a State may designate the positions of any one of the following

groupings of employees as a separate retirement system:

(1) The entire system;

(2) The employees of the State under the system;

(3) The employees of each political subdivision in the State under the system;

(4) The employees of the State and the employees of any one or more of the State's political subdivisions;

(5) The employees of any combination of the State's political subdivisions;

(6) The employees of each institution of higher learning, including junior colleges and teachers colleges;

(7) The employees of a hospital which is an integral part of a political subdivision; or

(8) The employees in police officers' positions or firefighters' positions, or both.

If State law requires a State or political subdivision to have a retirement system, it is considered established even though no action has been taken to establish the system.

(b) *Retirement system coverage groups.* A retirement system coverage group is a grouping of employees in positions under a retirement system. Employees in positions under the system have voted for coverage for the system by referendum and a State has provided coverage by agreement or modification of its agreement. It is not a permanent grouping. It exists only for referendum and coverage purposes and is not a separate group for reporting purposes. Once coverage has been obtained, the retirememt system coverage group becomes part of one of the absolute coverage groups described in § 404.1205(b).

(c) *What a retirement system coverage group consists of.* A retirement system coverage group consists of:

(1) Current employees—all employees whose services are not already covered by the agreement, who are in positions covered by the same retirement system on the date an agreement or modification of the agreement is made applicable to the system;

(2) Future employees—all employees in positions brought under the system after an agreement or modification of the agreement is signed; and

(3) Other employees—all employees in positions which had been under the retirement system but which were not under the retirement system when the group was covered (including ineligibles who had been optionally excluded from coverage under section 218(c)(3)(B) of the Act).

(d) *Referendum procedures.* Prior to signing the agreement or modification, the governor or an official of the State named by the governor (for an interstate instrumentality, its chief executive officer) must certify to the Commissioner that:

(1) All eligible employees were given at least 90 days' notice of the referendum;

(2) All eligible employees were given an opportunity to vote in the referendum;

(3) Only eligible employees were permitted to vote in the referendum;

(4) Voting was by secret written ballot on the question of whether service in positions covered by the retirement system should be included under an agreement;

(5) The referendum was conducted under the supervision of the governor or agency or individual named by him; and

(6) A majority of the retirement system's eligible employees voted for coverage under an agreement.

The State has two years from the date of a favorable referendum to enter into an agreement or modification extending coverage to the retirement system coverage group. If the referendum is unfavorable, another referendum cannot be held until at least one year after that unfavorable referendum.

(e) *Who is covered.* If a majority of the eligible employees in a retirement system vote for coverage, all employees in positions in that retirement system become covered.

(f) *Coverage of employees in positions under more than one retirement system.* (1) If an employee occupies two or more positions each of which is under a different retirement system, the employee's coverage in each position depends upon the coverage extended to each position under each system.

(2) If an employee is in a single position which is under more than one retirement system (because the employee's occupancy of that position permits her or him to become a member of more than one retirement system), the employee is covered when the retirement system coverage group including her or his position is covered under an agreement unless (A) he or she is not a member of the retirement system being covered and (B) he or she is a member of a retirement system which has not been covered. This rule also applies to the coverage of services in police officers' and firefighters' positions in States and interstate instrumentalities as discussed in §404.1212(c).

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38367, July 24, 1996; 62 FR 38451, July 18, 1997]

§404.1207 Divided retirement system coverage groups.

(a) *General.* Under section 218(d)(6)(C) of the Act certain States and under section 218(g)(2) of the Act all interstate instrumentalities may divide a retirement system based on whether the employees in positions under that system want coverage. The States having this authority are Alaska, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Vermont, Washington, and Wisconsin.

(b) *Divided retirement system coverage group.* A divided retirement system coverage group is a grouping under a retirement system of positions of members of the system who voted for coverage and positions of individuals who become members of the system (the ''yes'' group), and positions of members of the system who did not elect coverage (the ''no'' group) and ineligible employees (see §404.1208). For purposes of this section for groups covered after 1959, the term ''member'' also includes individuals who have an option to become members of the retirement system but have not done so. The position of a member in the ''no'' group can be covered if, within two years after the agreement or modification extending coverage to the ''yes'' group is executed, the State provides an opportunity to transfer the position to the covered ''yes'' group and the individual occupying the position makes a written request for the transfer. The members of the ''no'' group can also be covered if, by referendum, a majority of them vote for coverage. If the majority votes for coverage, all positions of the members of the ''no'' group become covered. There is no further subdivision of the ''no'' group into those who voted for and those who voted against coverage. If the State requests, the ineligibles in the ''no'' group may become part of the ''yes'' group and have their services covered.

(c) *Referendum procedures.* To divide a retirement system, the State must conduct a referendum among the system's employees. If the system is to be divided, the governor or an individual named by him must certify to the Secretary that:

(1) The referendum was held by written ballot on the question of whether members of a retirement system wish coverage under an agreement;

(2) All members of the retirement system at the time the vote was held had the opportunity to vote;

(3) All members of the system on the date the notice of the referendum was issued were given at least 90 days' notice regarding the referendum;

(4) The referendum was conducted under the supervision of the governor or agency or person designated by him; and

(5) The retirement system was divided into two parts, one composed of positions of members of the system who voted for coverage and the other composed of the remaining positions under the retirement system.

After the referendum the State may include those members who chose coverage under its agreement as a retirement system coverage group. The State has two years from the date of the referendum to enter into an agreement or modification extending coverage to that group.

§404.1208 Ineligible employees.

(a) *Definition.* An ineligible is an employee who, on first occupying a position under a retirement system, is not eligible for membership in that system because of a personal disqualification

like age, physical condition, or length of service.

(b) *Coverage of ineligible employees.* A State may, in its agreement or any modification to the agreement, provide coverage for the services of ineligible employees in one of three ways:

(1) As part of or as an addition to an absolute coverage group;

(2) As part of a retirement system coverage group covering all positions under the retirement system; or

(3) As part of or as an addition to a retirement system coverage group composed of those members in positions in a retirement system who chose coverage.

§ 404.1209 Mandatorily excluded services.

Some services are mandatorily excluded from coverage under a State's agreement. They are:

(a) Services of employees who are hired to relieve them from unemployment;

(b) Services performed in an institution by a patient or inmate of the institution;

(c) Transportation service subject to the Federal Insurance Contributions Act;

(d) Certain emergency services in case of fire, storm, snow, volcano, earthquake, flood or other similar emergency; and

(e) Services other than agricultural labor or student services which would be excluded from coverage if performed for a private employer.

(f) Services covered under section 210(a)(7)(F) of the Act. (See § 404.1200(b).)

[53 FR 32976, Aug. 29, 1988, as amended at 57 FR 59911, Dec. 17, 1992]

§ 404.1210 Optionally excluded services.

Certain services and positions may, if the State requests it, be excluded from coverage. These exclusions may be applied on a statewide basis or selectively by coverage groups. They are:

(a) Services in any class or classes of elective positions;

(b) Services in any class or classes of part-time positions;

(c) Services in any class or classes of positions where the pay is on a fee basis;

(d) Any agricultural labor or student services which would also be excluded if performed for a private employer; and

(e) For modifications executed after 1994, services performed by election officials or election workers if the payments for those services in a calendar year are less than $1000 for calendar years after 1994 and before 2000, or, for calendar years after 1999, are less than the $1000 base amount as adjusted pursuant to section 218(c)(8)(B) of the Act to reflect changes in wages in the economy. We will publish this adjustment of the $1000 base amount in the FEDERAL REGISTER on or before November 1 preceding the year for which the adjustment is made.

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38367, July 24, 1996]

§ 404.1211 Interstate instrumentalities.

For Social Security coverage purposes under section 218 of the Act, interstate instrumentalities are treated, to the extent practicable, as States, that is:

(a) They must be legally authorized to enter into an agreement with the Commissioner;

(b) They are subject to the same rules that are applied to the States;

(c) They may divide retirement systems and cover only the positions of members who want coverage; and

(d) They may provide coverage for firefighters and police officers in positions under a retirement system.

[53 FR 32976, Aug. 29, 1988, as amended at 61 FR 38368, July 24, 1996; 62 FR 38451, July 18, 1997]

§ 404.1212 Police officers and firefighters.

(a) *General.* For Social Security coverage purposes under section 218 of the Act, a police officer's or firefighter's position is any position so classified under State statutes or court decisions. Generally, these positions are in the organized police and fire departments of incorporated cities, towns, and villages. In most States, a police officer is a member of the ''police'' which is an organized civil force for

maintaining order, preventing and detecting crimes, and enforcing laws. The terms ''police officer'' and ''firefighter'' do not include services in positions which, although connected with police and firefighting functions, are not police officer or firefighter positions.

(b) *Providing coverage.* A State may provide coverage of:

(1) Police officers' and firefighters' positions not under a retirement system as part of an absolute coverage group; or

(2) Police officers' or firefighters' positions, or both, as part of a retirement system coverage group.

(c) *Police officers and firefighters in positions under a retirement system.* All States and interstate instrumentalities may provide coverage for employees in police officers' or firefighters' positions, or both, which are under a retirement system by following the majority vote referendum procedures in §404.1206(d). In addition, all interstate instrumentalities and the States listed in §404.1207 may use the desire for coverage procedures described in §404.1207.

[61 FR 38368, July 24, 1996]

HOW COVERAGE UNDER AGREEMENTS IS OBTAINED AND CONTINUES

§404.1214 Agreement for coverage.

(a) *General.* A State may enter into a written agreement with the Commissioner to provide for Social Security coverage for its employees or the employees of one or more of its political subdivisions. An interstate instrumentality may enter into a similar agreement for its employees. These agreements cover employees in groups of positions or by types of services rather than the individual employees.

(b) *Procedures.* A State or interstate instrumentality may request coverage by submitting to SSA a proposed written agreement for the desired coverage.

(c) *Authority to enter into an agreement for coverage*—(1) *Federal law.* Section 218(a) of the Act requires the Commissioner to enter into an agreement, at the request of the State, to extend Social Security coverage to the State's employees or those of its political subdivisions. Section 218(g) authorizes the Commissioner to enter into an agreement, at the request of an interstate instrumentality, to extend Social Security coverage to the employees of the interstate instrumentality.

(2) *State law.* State law must authorize a State or an interstate instrumentality to enter into an agreement with the Commissioner for Social Security coverage.

(d) *Provisions of the agreement.* The agreement must include:

(1) A description of the specific services to be covered and excluded;

(2) The State's promise to pay, to the Secretary of the Treasury, contributions equal to the sum of the taxes which would be required under the Federal Insurance Contributions Act from employers and employees if the employment were in the private sector;

(3) The State's promise to comply with the regulations the Commissioner prescribes for carrying out the provisions of section 218 of the Act; and

(4) Identification of the political subdivisions, coverage groups, or services being covered and the services that are excluded.

The agreement must be signed by the authorized State or interstate instrumentality official and the Commissioner or his or her designee.

(e) *Effective date.* The agreement must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the agreement is mailed or delivered by other means to the Commissioner. The agreement is effective after the effective date.

(f) *Applicability of agreement.* The agreement establishes the continuing relationship between the Commissioner and the State or interstate instrumentality except as it is modified (see §§404.1215–404.1217).

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1214 was revised, effective Aug. 29, 1988, with the exception of paragraph (d). Section 404.1214(d) contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1215 Modification of agreement.

(a) *General.* A State or interstate instrumentality may modify in writing its agreement, for example, to:

(1) Exclude, in limited situations, employee services or positions previously covered;

(2) Include additional coverage groups; or

(3) Include as covered services:

(i) Services of covered employees for additional retroactive periods of time; and

(ii) Services previously excluded from coverage.

(b) *Controlling date for retroactive coverage.* A State may specify in the modification a date to make all individuals in the coverage group who were in an employment relationship on that date eligible for retroactive coverage. This date is known as the controlling date for retroactive coverage. It can be no earlier than the date the modification is mailed or otherwise delivered to the Commissioner nor can it be later than the date the modification is signed by the Commissioner. If the State does not designate a controlling date, the date the modification is signed by the Commissioner is the controlling date.

(c) *Conditions for modification.* The provisions of section 218 of the Act which apply to the original agreement also apply to a modification to the agreement.

(d) *Effective date.* Generally, a modification must specify an effective date of coverage. However, the effective date cannot be earlier than the last day of the sixth calendar year preceding the year in which the modification is mailed or delivered by other means to the Commissioner. The modification is effective after the effective date.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1216 Modification of agreement to correct an error.

(a) *General.* If an agreement or modification contains an error, the State may correct the error by a subsequent modification to the agreement. For example, the agreement or modification incorrectly lists a covered service as an optionally excluded service or shows an improper effective date of coverage. In correcting this type of error, which affects the extent of coverage, the State must submit a modification along with evidence to establish that the error occurred. However, a modification is not needed to correct minor typographical or clerical errors. For example, an agreement or modification incorrectly lists School District No. 12 as School District No. 13. This type of error can be corrected based on a written request from the appropriate official of the State or interstate instrumentality.

(b) *Correction of errors involving erroneous reporting to the IRS—for wages paid prior to 1987.* Where a State or political subdivision makes reports and payments to the Internal Revenue Service under the provisions of the Federal Insurance Contributions Act which apply to employees in private employment in the mistaken belief that this action would provide coverage for its employees, the State may provide the desired coverage for those same periods of time by a subsequent modification to its agreement. If State law permits, the State may make that coverage effective with the first day of the first period for which the erroneous reports and payments were made. (In this instance, the limitation on retroactive coverage described in § 404.1215(d) is not applicable.) Where the State does not want to provide such retroactive coverage or is not permitted to do so by State law, the State may provide the coverage for the affected coverage group as of a specified date (§ 404.1215(b)). The coverage would then apply to the services performed by individuals as members of the coverage group

(1) Who were employees on that date, and

(2) Whose wages were erroneously reported to IRS, and

(3) For whom a refund of FICA taxes has not been obtained at the time the Commissioner.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1216 was revised, effective August 29, 1988 with the exception of paragraph (a). Section 404.1216(a) contains reporting

and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1217 Continuation of coverage.

The coverage of State and local government employees continues as follows:

(a) *Absolute coverage group.* Generally, the services of an employee covered as a part of an absolute coverage group (see § 404.1205) continue to be covered indefinitely. A position covered as a part of an absolute coverage group continues to be covered even if the position later comes under a retirement system. This includes policemen's and firemen's positions which are covered with an absolute coverage group.

(b) *Retirement system coverage group.* Generally, the services of employees in positions covered as a part of a retirement system coverage group continue to be covered indefinitely. For a retirement system coverage group made up of members who chose coverage, a position continues to be covered until it is removed from the retirement system and is no longer occupied by a member who chose coverage or by a new member of the system. Coverage is not terminated because the positions are later covered under additional retirement systems or removed from coverage under a retirement system, or because the retirement system is abolished with respect to the positions. However, if the retirement system has been abolished, newly created or reclassified positions or positions in a newly created political subdivision cannot be covered as a part of the retirement system coverage group. If the retirement system is not abolished, a newly created or reclassified position is a part of the coverage group if the position would have been a part of the group had it existed earlier. If the retirement system coverage group is made up of members who chose coverage, the newly created or reclassified position is a part of the coverage group if it is occupied by a member who chose coverage or by a new member.

§ 404.1218 Resumption of coverage.

Before April 20, 1983, an agreement could be terminated in its entirety or with respect to one or more coverage groups designated by the State. Coverage of any coverage group which has been previously terminated may be resumed by a modification to the agreement.

§ 404.1219 Dissolution of political subdivision.

If a political subdivision whose employees are covered under the agreement is legally dissolved, the State shall give us satisfactory evidence of its dissolution or nonexistence. The evidence must establish that the entity is not merely inactive or dormant, but that it no longer legally exists. We will notify the State whether the evidence is satisfactory.

HOW TO IDENTIFY COVERED EMPLOYEES

§ 404.1220 Identification numbers.

(a) *State and local governments.* When a State submits a modification to its agreement under section 218 of the Act, which extends coverage to periods prior to 1987, SSA will assign a special identification number to each political subdivision included in that modification. SSA will send the State a Form SSA–214–CD, ''Notice of Identifying Number,'' to inform the State of the special identification number(s). The special number will be used for reporting the pre-1987 wages to SSA. The special number will also be assigned to an interstate instrumentality if pre-1987 coverage is obtained and SSA will send a Form SSA–214–CD to the interstate instrumentality to notify it of the number assigned.

(b) *Coverage group number for coverage groups.* If a State's agreement provides coverage for a State or a political subdivision based on designated proprietary or governmental functions, the State shall furnish a list of those groups. The list shall identify each designated function and the title and business address of the official responsible for filing each designated group's wage report. SSA assigns a coverage group number to each designated group based on the information furnished in the list.

(c) *Unit numbers for payroll record units.* SSA assigns, at a State's request, unit numbers to payroll record units within a State or political subdivision.

When a State requests separate payroll record unit numbers, it must furnish the following:

(1) The name of each payroll record unit for the coverage group; and

(2) The title and business address of the official responsible for each payroll unit.

(d) *Unit numbers where contribution amounts are limited—for wages paid prior to 1987.* An agreement, or modification of an agreement, may provide for the computation of contributions as prescribed in § 404.1256 for some employees of a political subdivision. In this situation, SSA assigns special unit numbers to the political subdivision to identify those employees. SSA does not assign a special unit number to a political subdivision in which the contributions for all employees are computed as prescribed in § 404.1256.

(e) *Use.* For wages paid prior to 1987, the employer shall show the appropriate SSA-issued identifying number, including any coverage group or payroll record unit number, on records, reports, returns, and claims to report wages, adjustments, and contributions.

[53 FR 32976, Aug. 29, 1988, as amended at 60 FR 42433, Aug. 16, 1995; 64 FR 33016, June 21, 1999]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1220 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

WHAT RECORDS OF COVERAGE MUST BE KEPT

§ 404.1225 Records—for wages paid prior to 1987.

(a) *Who keeps the records.* Every State which enters into an agreement shall keep, or require the political subdivisions whose employees are included under its agreement to keep, accurate records of all remuneration (whether in cash or in a medium other than cash) paid to employees performing services covered by that agreement. These records shall show for each employee:

(1) The employee's name, address, and Social Security number;

(2) The total amount of remuneration (including any amount withheld as contributions or for any other reason) and the date the remuneration was paid and the period of services covered by the payment;

(3) The amount of remuneration which constitutes wages (see § 404.1041 for wages and §§ 404.1047–404.1059 for exclusions from wages); and

(4) The amount of the employee's contribution, if any, withheld or collected, and if collected at a time other than the time such payment was made, the date collected. If the total remuneration (paragraph (a)(2) of this section) and the amount which is subject to contribution (paragraph (a)(3) of this section) are not equal, the reason shall be stated.

The State shall keep copies of all returns, reports, schedules, and statements required by this subpart, copies of claims for refund or credit, and copies of documents about each adjustment made under § 404.1265 or § 404.1271 as part of its records. These records may be maintained by the State or, for employees of a political subdivision, by the political subdivision. Each State shall use forms and systems of accounting as will enable the Commissioner to determine whether the contributions for which the State is liable are correctly figured and paid.

(b) *Place and period of time for keeping records.* All records required by this section shall:

(1) Be kept at one or more convenient and safe locations accessible to reviewing personnel (see § 404.1232(a));

(2) Be available for inspection by reviewing personnel at any time; and

(3) Be maintained for at least four years from the date of the event recorded. (This four-year requirement applies regardless of whether, in the meantime, the employing entity has been legally dissolved or, before April 20, 1983, the agreement was terminated in its entirety or in part.)

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1225 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

REVIEW OF COMPLIANCE BY STATE WITH ITS AGREEMENT

§404.1230 Onsite review program.

To ensure that the services of employees covered by a State's agreement are reported and that those employees receive Social Security credit for their covered earnings, we periodically review the source records upon which a State's contribution returns and wage reports are based. These reviews are designed:

(a) To measure the effectiveness of the State's systems for ensuring that all wages for those employees covered by its agreement are reported and Social Security contributions on those wages are paid;

(b) To detect any misunderstanding of coverage or reporting errors and to advise the State of the corrective action it must take; and

(c) To find ways to improve a State's recordkeeping and reporting operations for the mutual benefit of the State and SSA.

§404.1231 Scope of review.

The onsite review focuses on four areas:

(a) State's controls and recordkeeping—to assess a State's systems for assuring timely receipt, correctness, and completeness of wage reports and contribution returns;

(b) Instruction, education, and guidance a State provides local reporting officials—to assess a State's systems for assuring on a continuing basis that all reporting officials and their staffs have the necessary instructions, guidelines, and training to meet the State's coverage, reporting and recordkeeping requirements;

(c) Compliance by reporting officials—to assess a State's systems for assuring that the reporting officials in the State have adequate recordkeeping procedures, are properly applying the appropriate provisions of the State's agreement, and are complying with reporting requirements; and

(d) Quality control with prompt corrective action—to assess a State's systems for assuring that its reports and those of its political subdivisions are correct, for identifying the causes and extent of any deficiencies, and for promptly correcting these deficiencies.

§404.1232 Conduct of review.

(a) Generally, SSA staff personnel conduct the onsite review. Occasionally, members of the Office of the Inspector General may conduct or participate in the review.

(b) The review is done when considered necessary by SSA or, if practicable, in response to a State's specific request for a review.

(c) All pertinent source records prepared by the State or its political subdivisions are reviewed, on site, to verify the wage reports and contribution returns. We may review with the appropriate employees in a subdivision those source records and how the information is gathered, processed, and maintained. We notify the State's Social Security Administrator when we plan to make the review and request her or him to make the necessary arrangements.

(d) The review is a cooperative effort between SSA and the States to improve the methods for reporting and maintaining wage data to carry out the provisions of the agreement.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§404.1234 Reports of review's findings.

We provide the State Social Security Administrator with reports of the review's findings. These reports may contain coverage questions which need development and resolution and reporting errors or omissions for the State to correct promptly. These reports may also recommend actions the State can take to improve its information gathering, recordkeeping, and wage reporting systems, and those of its political subdivisions.

HOW TO REPORT WAGES AND CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§404.1237 Wage reports and contribution returns—general—for wages paid prior to 1987.

(a) *Wage reports.* Each State shall report each year the wages paid each covered employee during that year. With the wage report the State shall also

identify, as prescribed by SSA, each political subdivision by its assigned identification number and, where appropriate, any coverage group or payroll record unit number assigned.

(b) *Wage reports of remuneration for agricultural labor.* A State may exclude from its agreement any services of employees the remuneration for which is not wages under section 209(h)(2) of the Act. Section 209(h)(2) excludes as wages the cash remuneration an employer pays employees for agricultural labor which is less than $150 in a calendar year, or, if the employee performs the agricultural labor for the employer on less than 20 days during a calendar year, the cash remuneration computed on a time basis. If a State does exclude the services and the individual meets the cash-pay or 20-day test described in § 404.1056, the State shall identify on the wage report and on any adjustment report each individual performing agricultural labor and the amount paid to her or him.

(c) *Contribution returns.* The State shall forward the contribution return as set out in § 404.1249(b). It shall make contribution payments under § 404.1262.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1237 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1239 Wage reports for employees performing services in more than one coverage group—for wages paid prior to 1987.

(a) *Employee of State in more than one coverage group.* If a State employee is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in § 404.1047, as though the wages were paid by only one of the coverage groups.

(b) *Employee of political subdivision in more than one coverage group.* If an employee of a political subdivision is in more than one coverage group, the State shall report the employee's total wages, up to the annual wage limitations in § 404.1047, as though the wages were paid by only one of the coverage groups.

(c) *Employee of State and one or more political subdivisions.* If an individual performs covered services as an employee of the State and an employee of one or more political subdivisions and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the State and each political subdivision shall report the amount of covered wages it paid the employee up to the annual wage limitations in § 404.1047.

(d) *Employee of more than one political subdivision.* If an individual performs covered services as an employee of more than one political subdivision and the State agreement does not provide for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, each political subdivision shall report the covered wages it paid the employee up to the annual wage limitations in § 404.1047.

(e) *Employee performing covered services for more than one political entity where section 218(e)(2) of the Act is applicable.* If an agreement provides for limiting contributions under section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509, the reporting officials compute the total amount of wages paid the employee by two or more political subdivisions of a State, or a State and one or more of its political subdivisions, which were subject to section 218(e)(2) of the Act. The State reports the amount of wages paid up to the annual wage limitations in § 404.1047. The employee is treated as having only one employer. If the employee also had wages not subject to section 218(e)(2) of the Act, the State shall report those wages separately.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1239 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1242 Back pay.

(a) *Back pay defined.* Back pay is pay received in one period of time which would have been paid in a prior period of time except for a wrongful or improper action taken by an employer. It includes pay made under Federal or

State laws intended to create an employment relationship (including situations where there is unlawful refusal to hire) or to protect an employee's right to wages.

(b) *Back pay under a statute.* Back pay under a statute is a payment by an employer following an award, determination or agreement approved or sanctioned by a court or administrative agency responsible for enforcing a Federal or State statute protecting an employee's right to employment or wages. Examples of these statutes are:

(1) National Labor Relations Act or a State labor relations act;

(2) Federal or State laws providing reemployment rights to veterans;

(3) State minimum wage laws; and

(4) Civil Rights Act of 1964.

Payments based on legislation comparable to and having a similar effect as those listed in this paragraph may also qualify as having been made under a statute. Back pay under a statute, excluding penalties, is wages if paid for covered employment. It is allocated to the periods of time in which it should have been paid if the employer had not violated the statute. For backpay awards affecting periods prior to 1987, a State must fill a wage report and pay the contributions due for all periods involved in the back pay award under the rules applicable to those periods.

(c) *Back pay not under a statute.* Where the employer and the employee agree on the amount payable without any award, determination or agreement approved or sanctioned by a court or administrative agency, the payment is not made under a statute. This back pay cannot be allocated to prior periods of time but must be reported by the employer for the period in which it is paid.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1242 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1243 Use of reporting forms—for wages paid prior to 1987.

(a) *Submitting wage reports.* In the form and manner required by SSA, a State shall submit an annual report of the covered wages the State and its political subdivisions paid their employees. Any supplemental, adjustment, or correctional wage report filed is considered a part of the State's wage report.

(b) *Correction of errors.* If a State fails to report or incorrectly reports an employee's wages on its wage report, the State shall submit a corrective report as required by SSA.

(c) *Reporting on magnetic tape or other media.* After approval by SSA, a State may substitute magnetic tape or other media for any form required for submitting a report or reporting information.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1243 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1247 When to report wages—for wages paid prior to 1987.

A State shall report wages for the calendar year in which they were actually paid. If the wages were constructively paid in a prior calendar year, the wages shall be reported for the prior year (see §404.1042(b) regarding constructive payment of wages).

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1247 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1249 When and where to make deposits of contributions and to file contribution returns and wage reports—for wages paid prior to 1987.

(a) *Deposits of contributions.* The State shall pay contributions in the manner required in §404.1262. (For failure to make deposits when due see §404.1265.) The contribution payment is considered made when received by the appropriate Federal Reserve bank or branch (see §404.1262). Except as provided in paragraphs (b) (2) and (3) and paragraph (c) of this section, contributions are due and payable as follows:

(1) *For wages paid before July 1, 1980.* Contribution payments for wages paid in a calendar quarter are due on the 15th day of the second month following the end of the calendar quarter during which the wages were paid.

(2) *For wages paid beginning July 1, 1980, and before January 1984.* Contribution payments for wages paid in a calendar month are due within the thirty day period following the last day of that month.

(3) *For wages paid after December 1983 and prior to 1987.* Contribution payments for wages paid in the first half of a calendar month are due on the last day of that month. Contribution payments for wages paid in the second half of that calendar month are due on the fifteenth day of the next month. (For purposes of this section, the first half of a calendar month is the first 15 days of that month and the second half is the remainder of that month.)

(b) *Contribution returns and wage reports*—(1) *Where to be filed.* The State shall file the original copies of all contribution returns, wage reports, and adjustment reports with the SSA.

(2) *When to be filed*—(i) *For years prior to execution of agreement or modification.* If an agreement or modification provides for the coverage of employees for periods prior to 1987, the State shall pay contributions due and shall file wage reports with SSA for these periods within 90 days after the date of the notice that the Commissioner has signed the agreement or modification.

(ii) *For year of execution of agreement or modification.* If the agreement or modification provides for the coverage of employees for the year of execution of the agreement or modification, the State may, within 90 days after the date of the notice that the Commissioner has signed the agreement or modification, submit a single contribution return and pay all contributions due for the following periods:

(A) The month in which the agreement or modification was signed;

(B) Any prior months in that year; and

(C) Any subsequent months before January 1984 (half-months after December 1983) whose contribution return and payment due date is within this 90 day period. The State shall file wage reports for that year by February 28 of the year following the date of execution or within 90 days of the date of the notice, whichever is later.

(iii) *For years after execution of agreement or modification.* Except as described in paragraph (b)(2)(ii) of this section, when the State pays its contributions under paragraph (a) of this section, it shall also file a contribution return. The State shall file the wage report for any calendar year after the year of execution of the agreement or modification by February 28 of the following calendar year.

(iv) For good cause shown, and upon written request by a State, the Commissioner may allow additional time for filing the reports and paying the related contributions described in paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(3) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day for filing the wage report falls on a weekend, legal holiday or Federal nonworkday, the State may file the wage report on the next Federal workday. If the due date for paying contributions for the wages paid in a period (as specified in paragraph (a) of this section) falls on a weekend, legal holiday or Federal nonworkday, the State shall pay the contributions and shall file the contribution return no later than—

(i) The preceding Federal workday for wages paid in July 1980 through December 1983;

(ii) The next Federal workday for wages paid before July 1980 or after December 1983.

(4) *Submitting reports and payments.* When submitting the contribution returns or wage reports the State shall release them in time to reach SSA by the due date. When submitting contribution payments as described in § 404.1262, the State shall release the payments in time to reach the appropriate Federal Reserve bank or branch by the due date. In determining when to release any returns, reports, or payments the State shall provide sufficient time for them to timely reach their destination under the method of submission used, e.g., mail or electronic transfer of funds.

(c) *Payments by third party on account of sickness or accident disability.* Where a third party makes a payment to an employee on account of sickness or accident disability which constitutes wages for services covered under a State

agreement, the wages will be considered, for purposes of the deposits required under this section, to have been paid to the employee on the date on which the employer receives notice from the third party of the amount of the payment. No interest will be assessed for failure to make a timely deposit of contributions due on such wages for which a deposit was made after December 1981 and before July 1982, to the extent that the failure to make the deposit timely is due to reasonable cause and not willful neglect.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1249 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1251 Final reports—for wages paid prior to 1987.

If a political subdivision is legally dissolved, the State shall file a final report on that entity. The report shall include each coverage group whose existence ceases with that of the entity. It shall:

(a) Be marked ''final report'';

(b) Cover the period during which final payment of wages subject to the agreement is made; and

(c) Indicate the last date wages were paid.

With the final report, the State shall submit a statement showing the title and business address of the State official responsible for keeping the State's records and of each State and local official responsible for keeping the records for each coverage group whose existence is ended. The State shall also identify, as prescribed by SSA, each political subdivision by its assigned number and, where applicable, any coverage group or payroll record unit number assigned.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1251 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

WHAT IS A STATE'S LIABILITY FOR CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§404.1255 State's liability for contributions—for wages paid prior to 1987.

A State's liability for contributions equals the sum of the taxes which would be imposed by sections 3101 and 3111 of the Internal Revenue Code of 1954, if the services of the employees covered by the State's agreement were employment as defined in section 3121 of the Code. The State's liability begins when those covered services are performed, for which wages are actually or constructively paid to those individuals, including wages paid in a form other than cash (see §404.1041(d)). If an agreement is effective retroactively, the State's liability for contributions on wages paid during the retroactive period begins with the date of execution of the agreement or applicable modification. Where coverage of a coverage group has been terminated, the State is liable for contributions on wages paid for covered services even if the wages are paid after the effective date of termination of coverage.

§404.1256 Limitation on State's liability for contributions for multiple employment situations—for wages paid prior to 1987.

(a) *Limitation due to multiple employment.* Where an individual in any calendar year performs covered services as an employee of a State and as an employee of one or more political subdivisions of the State, or as an employee of more than one political subdivision; and the State provides all the funds for payment of the amounts which are equivalent to the taxes imposed on the employer under FICA on that individual's remuneration for those services; and no political subdivision reimburses the State for paying those amounts; the State's agreement or modification of an agreement may provide that the State's liability for the contributions on that individual's remuneration shall be computed as though the individual had performed services in employment for only one political subdivision. The State may then total the individual's covered wages from all these governmental employers and compute the

contributions based on that total subject to the wage limitations in § 404.1047.

(b) *Identification of employees in multiple employment.* An agreement or modification of an agreement providing for the computation of contributions as described in paragraph (a) of this section shall identify the class or classes of employees to whose wages this method of computing contributions applies. For example, the State may provide that such computation shall apply to the wages paid to all individuals for services performed in positions covered by a particular retirement system, or to the wages paid to all individuals who are members of any two or more coverage groups designated in an agreement or modification. The State shall promptly notify SSA if the conditions in paragraph (a) of this section are no longer met by any class or classes of employees identified in an agreement or modification. In its notification, the State shall identify each class of employees and the date on which the conditions ceased to be met.

(c) *Effective date.* In the agreement or modification, the State shall provide that the computation of contributions shall apply to wages paid after the effective date stated in the agreement or modification. That date may be the last day of any calendar year; however, it may be no earlier than January 1 of the year in which the agreement or modification is submitted to SSA.

FIGURING THE AMOUNT OF THE STATE'S CONTRIBUTIONS—FOR WAGES PAID PRIOR TO 1987

§ 404.1260 Amount of contributions—for wages paid prior to 1987.

The State's contributions are equal to the product of the applicable contribution rate (which is equivalent to both the tax rates imposed under sections 3101 and 3111 of the Internal Revenue Code) times the amount of wages actually or constructively paid for covered services each year (subject to the wage limitations in § 404.1047) to the employee.

§ 404.1262 Manner of payment of contributions by State—for wages paid prior to 1987.

When paying its contributions, the State shall deposit its payment at the specific Federal Reserve bank or branch designated by SSA.

§ 404.1263 When fractional part of a cent may be disregarded—for wages paid prior to 1987.

In paying contributions to a Federal Reserve bank or branch, a State may disregard a fractional part of a cent unless it amounts to one-half cent or more, in which case it shall be increased to one cent. Fractional parts of a cent shall be used in computing the total of contributions.

IF A STATE FAILS TO MAKE TIMELY PAYMENTS—FOR WAGES PAID PRIOR TO 1987

§ 404.1265 Addition of interest to contributions—for wages paid prior to 1987.

(a) *Contributions not paid timely.* If a State fails to pay its contributions to the appropriate Federal Reserve bank or branch (see § 404.1262), when due under § 404.1249(a), we add interest on the unpaid amount of the contributions beginning with the date the payment was due, except as described in paragraphs (b) and (c) of this section. Interest, if charged, begins with the due date even if it is a weekend, legal holiday or Federal nonwork day. Interest is added at the rate prescribed in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

(b) *Method of making adjustment.* (1) If a State shall file a contribution return and shall accompany such return with payment of contributions due and payable as reported on such return in accordance with § 404.1249 but the amount of the contributions reported and paid is less than the correct amount of contributions due and payable and the underpayment of contributions is attributable to an error in computing the contributions (other than an error in applying the rate of contributions in effect at the time the wages were paid), the State shall adjust the underpayment by reporting the additional

amount due by reason of such underpayment either as an adjustment of total contributions due with the first wage report filed after notification of the underpayment by the Social Security Administration, or as a single adjustment of total contributions due with any contribution return filed prior to the filing of such wage report.

(2) If an underpayment of contributions is due to an underreporting of or a failure to report one or more employees:

(i) Where the underreporting or failure to report has been ascertained by the State, the State may cause an adjustment by filing a report within 30 days after ascertainment of the error by the State;

(ii) Where the underreporting or failure to report has been ascertained by the Social Security Administration, a notification of underpayment shall be forwarded to the State, and the State may cause an adjustment of the underpayment by returning to the Social Security Administration, within 30 days from the date of the notification, a copy of the notification of underpayment and the State's corrected report. The report shall show the amount of wages, if any, erroneously reported for the reporting period and the correct amount of wages that should have been reported and the identification number of the State or the political subdivision for each employee who was omitted or erroneously reported. The filing to correct an underreporting of or a failure to report one or more employees' wages shall not constitute an adjustment under this section unless the wages were erroneously omitted or erroneously reported.

(c) *Payment.* The amount of each underpayment adjusted in accordance with this section shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, without interest, at the time of reporting the adjustment; except that where any amounts due with respect to such an adjustment had been paid in error to IRS and a refund thereof timely requested from, or instituted by, IRS, the amount of underpayment adjusted in accordance with this section, plus any interest paid by IRS on the amount of such underpayment, shall be paid to the Federal Reserve Bank, or branch thereof, serving the district in which the State is located, at the time of reporting the adjustment or within 30 days after the date of issuance by IRS of the refund of the erroneous payments, whichever is later. Except as provided in the preceding sentence of this paragraph, if an adjustment is reported pursuant to paragraph (b) of this section, but the amount thereof is not paid when due, interest thereafter accrues.

(d) *Verifying contributions paid against reported wages.* We check the computation of contributions to verify that a State has paid the correct amount of contributions on the wages it reports for a calendar year (see §404.1249(b)(2)). If we determine that a State paid less than the amount of contributions due for that year, we add interest to the amount of the underpayment. We would add interest beginning with the date the unpaid contributions were initially due to the date those contributions are paid. However, if the total amount of the underpayment is 5 percent or less than 5 percent of the contributions due for a calendar year based upon the State's wage report and the State deposits the underpaid amount within 30 days after the date of our notification to the State of the amount due, the State may request that the interest on the underpaid amount be waived for good cause. This request must be made within 30 days of our notification to the State of the amount due. Such requests will be evaluated on an individual basis. The evaluation will include, but not be limited to, consideration of such factors as the circumstances causing the late payment, the State's past record of late payments and the amount involved.

Examples (1) The records of a political subdivision for the month of June are destroyed by fire. The State makes an estimated deposit of contributions for the month of June for that political subdivision and deposits contributions for the month of June for all other political subdivisions based on actual records. At the time SSA verifies contributions paid against reported wages, we discover that the State has paid only 97 percent of its total liability for the year. Within 30 days after we notify it of the amount due, the State asks that we waive the interest on

the unpaid amount and the State deposits the unpaid amount. In this situation, we would waive the interest on the unpaid contributions.

(2) We would waive interest if:

(i) Some of the political subdivisions made small arithmetical errors in preparing their reports of wages,

(ii) After verification of the contributions paid against reported wages, SSA discovers that minimal additional contributions are due,

(iii) Within 30 days of our notice to the State regarding this underpayment the State, which usually makes its deposits timely, pays the amount due, and

(iv) Within that same 30 day period the State requests that we waive the interest due.

(3) We would not waive interest where a State frequently has problems depositing its contributions timely. Reasons given for the delays are, e.g., the computer was down, the 5 p.m. mail pickup was missed, one of the school district reports was misplaced. If requested we would not waive interest on this State's late payment of contributions based upon its past record of late payments and because of the circumstances cited.

(e) *Due date is on a weekend, legal holiday or Federal nonworkday.* If the last day of the 30-day periods specified in paragraphs (b) and (d) of this section is on a weekend, legal holiday or Federal nonworkday, the State shall make the required deposit or request for waiver of payment of interest on the next Federal workday.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1265 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1267 Failure to make timely payments—for wages paid prior to 1987.

If a State does not pay its contributions when due, the Commissioner has the authority under section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509 to deduct the amounts of the unpaid contributions plus interest at the rate prescribed from any amounts certified by her or him to the Secretary of the Treasury for payments to the State under any other provision of the Social Security Act. The Commissioner notifies the Secretary of the Treasury of the amounts deducted and requests that the amount be credited to the Trust Funds. Amounts deducted are considered paid to the State under the other provision of the Social Security Act.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

HOW ERRORS IN REPORTS AND CONTRIBUTIONS ARE ADJUSTED—FOR WAGES PAID PRIOR TO 1987

§ 404.1270 Adjustments in general—for wages paid prior to 1987.

States have the opportunity to adjust errors in the payment of contributions. A State but not its political subdivisions is authorized to adjust errors in the underpayment of contributions. Similarly, the State shall file all claims for credits or refunds and SSA makes the credits and refunds only to the State. Generally, we do not refund contributions in cash to a State unless the State is not expected to have future liability for contributions under section 218 of the Act.

§ 404.1271 Adjustment of overpayment of contributions—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions, the State shall adjust the overpayment with the next contribution return filed on which the amount owed equals or exceeds the amount of the overpayment.

(b) *Overpayment due to overreporting of wages*—(1) *Report to file.* If the overpayment is due to the State's reporting more than the correct amount of wages paid to one or more employees during a reporting period and the overpayment is not adjusted under paragraph (a) of this section, the State shall file a report on the appropriate form showing:

(i) The corrected wage data as prescribed by SSA; and

(ii) The reason why the original reporting was incorrect.

(2) *Refund or credit of overpayment where section 218(e)(2) of the Act not applicable.* If:

(i) The State collected contributions from employees in excess of the amount of taxes that would have been required under section 3101 of the Internal Revenue Code; and

(ii) The State paid to the Secretary of the Treasury those contributions plus a matching amount in excess of the taxes which would have been required from an employer under section 3111 of the Code; and

(iii) The services of the employees in question would have constituted employment under section 3121(b) of the Code; and

(iv) Section 218(e)(2) of the Act as it read prior to the enactment of Pub. L. 99–509 does not apply (see §404.1256(a)), then the State shall adjust the overpaid contributions under paragraph (b)(1) of this section. With its adjustment the State, where appropriate, shall include on the prescribed form a statement that the employees from whom the excess contributions were collected have not received nor expect to receive a refund of excess contributions under section 6413(c) of the Internal Revenue Code of 1954 (see §404.1275(b)). Generally, if the State does not include this statement with its adjustment request, we only refund or credit the State for up to one-half of the overpaid amount.

(c) *Refund or credit of overpayment where section 218(e)(2) of the Act applicable*—(1) *General.* If—

(i) The overreporting of the amount of wages paid to one or more employees during a reporting period(s) is due to a computation of contributions under §404.1256 for a year or years prior to the year in which the agreement or modification providing for the computation is entered into, or

(ii) The overreporting is due to a failure to compute §404.1256,

the State shall adjust the overpayment under paragraph (b)(1) of this section. An overpayment due to overreported wages which does not result from the computation of contributions or a failure to compute contributions under §404.1256 shall also be adjusted by the State under paragraph (b)(1) of this section. If the adjustment of the overpayment results in an underreporting of wages for any employee by the State or any political subdivision, the State shall include with the report adjusting the overpayment a report adjusting each underreporting. If the adjustment of the overpayment does not result in an underreporting of wages for any employee by the State or any political subdivision, the State shall include with the report adjusting the overpayment a statement that the adjustment of the overpayment does not result in any underreporting.

(2) *Amount of refund or credit.* If the State collects excess contributions from employees, the State's claim for refund or credit is limited to the overpaid amounts. (See §404.1275 relating to adjustment of employee contributions.) If—

(i) The State collected the correct amount of contributions from employees based on the amount of wages reported and the Forms W–2 issued to the employees show only the amount of contributions actually collected, but the amount of wages reported is being adjusted downward, or

(ii) The State collects excess contributions from employees but Forms W–2 have not been issued for an amount of wages which is being adjusted downward, the State may claim a refund or credit for the overpaid amounts. Where the State's claim for refund or credit is for the total overpaid amount, the adjustment report shall include a statement that excess contributions have not been collected from employees, or, where excess contributions have been collected, that Forms W–2 have not been issued and that, when issued, they will show the correct amount of employee contributions.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, §404.1271 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§404.1272 Refund or recomputation of overpayments which are not adjustable—for wages paid prior to 1987.

(a) *General.* If a State pays more than the correct amount of contributions or interest to the appropriate Federal Reserve bank or branch (see §404.1262), and no adjustment in the amount of reported wages is necessary, that State may file a claim for refund or recomputation of the overpayment.

(b) *Form of claim.* No special form is required to make a claim for a refund

or recomputation. If a credit is taken under § 404.1271, a claim is not required.

(c) *Proof of representative capacity*. If a report or return is made by an authorized official of the State who ceases to act in an official capacity and a claim for a refund is made by a successor official, the successor official must submit with the claim written evidence showing that he or she has the authority to make a claim for and receive a refund of any contributions paid by the former official. The written evidence is not necessary if the successor official has previously filed one or more reports or returns which contain her or his signature and official title.

EFFECTIVE DATE NOTE: At 53 FR 32976, Aug. 29, 1988, § 404.1272 was revised. This amendment contains reporting and recordkeeping requirements and will become effective upon approval by the Office of Management and Budget.

§ 404.1275 Adjustment of employee contributions—for wages paid prior to 1987.

The amount of contributions a State deducts from an employee's remuneration for covered services, or any correction of that amount, is a matter between the employee and the State or political subdivision. The State shall show any correction of an employee's contribution on statements it furnishes the employee under § 404.1225 of this part. Where the State issues an employee a Form W–2 and then submits an overpayment adjustment but claims less than the total overpaid amount as a refund or credit, the State shall not correct the previously issued Form W–2 to reflect that adjustment.

[53 FR 32976, Aug. 29, 1988, as amended at 65 FR 16813, Mar. 30, 2000]

§ 404.1276 Reports and payments erroneously made to Internal Revenue Service-transfer of funds—for wages paid prior to 1987.

(a) *General*. In some instances, State or local governmental entities not covered under an agreement make reports and pay contributions to IRS under the Federal Insurance Contributions Act (FICA) procedures applicable to private employers in the mistaken belief that this provides Social Security coverage under section 218 of the Act for their employees. In other instances, entities which are covered under an agreement erroneously report to IRS, or a State or local government employee reports other employees to IRS or reports to IRS as a self-employed individual. Where these reports and payments are erroneously made to IRS, the State may correct the error and obtain coverage under its agreement as described in paragraphs (b) through (f) of this section.

(b) *Political subdivision not included in the State agreement*. We notify the State that if it desires coverage, it may be provided by either a regular modification or an error modification, depending on the circumstances (§§ 404.1215 and 404.1216). In most cases, the State may obtain coverage by a regular modification. If a regular modification cannot be used (e.g., State law does not permit the retroactive effective date which would be desired), the State may use an error modification. The effective date of either modification depends on the facts of the situation being corrected.

(c) *Political subdivision included in the agreement*. If a political subdivision included in the agreement erroneously makes reports and payments under FICA procedures, the State must correct the reportings for periods not barred by the statute of limitations. If the covered entity reported both under the agreement and under FICA procedures, we notify IRS and make necessary corrections in the earnings records. We also advise the State that the entity which reported under FICA procedures should request a refund of payments erroneously made to IRS.

(d) *State and local government employees erroneously reported as employees of individual or as self-employed*—(1) *Covered entity*. If employees of a covered entity are erroneously reported as employees of an individual or as self-employed, we advise the State that the individual who made the reports should request a refund from IRS for periods not barred by the statute of limitations. We require the State to file correctional reports and returns for any periods open under the State and local statute of limitations.

(2) *Noncovered entity*. We advise the State that the individual who made the

reports should request a refund from IRS for the periods not barred by the statute of limitations. If the State wishes to provide coverage, it must submit a modification as discussed in paragraph (b) of this section. If the State does not wish to provide coverage, we void the reports. Amounts reported for periods barred by the statute of limitations remain on the earnings records.

(e) *Filing wage reports and paying contributions.* Generally, the entity or individual that makes the erroneous reports and payments requests the refund from IRS for periods not barred by the statute of limitations. The State files the necessary reports with SSA and pays any contributions due. The reports shall conform to the coverage provided by the agreement to the extent permitted by the statute of limitations. The due date for these reports depends on whether original reports or adjustment reports are involved. Reports and contribution returns for the entire retroactive period of coverage provided by a regular or error modification are due 90 days after the date of execution of the modification. The time limitations for issuing assessments and credits or refunds extend from this due date. Thus, SSA may issue assessments or credits or refunds for periods barred to refund by IRS. The State may request that reports and payments for the IRS barred periods be considered made under the agreement as described in paragraph (f) of this section.

(f) *Use of transfer procedure.* In limited situations, the State may request that reports and payments the State or a political subdivision (but not an individual) erroneously made under FICA procedures and which have been posted to the employee's earnings record be considered made under the State's agreement. We use a transfer procedure to do this. The transfer procedure may be used only where

(1) The periods are open to assessment under the State and local statute of limitations;

(2) The erroneous reports to be transferred are posted to SSA's records;

(3) The periods are barred to refund under the IRS statute of limitations; and

(4) A refund is not obtained from IRS by the reporting entity.

HOW OVERPAYMENTS OF CONTRIBUTIONS ARE CREDITED OR REFUNDED—FOR WAGES PAID PRIOR TO 1987

§404.1280 Allowance of credits or refunds—for wages paid prior to 1987.

If a State pays more than the amount of contributions due under an agreement, SSA may allow the State, subject to the time limitations in §404.1282 and the exceptions to the time limitations in §404.1283, a credit or refund of the overpayment.

§404.1281 Credits or refunds for periods of time during which no liability exists—for wages paid prior to 1987.

If a State pays contributions for any period of time for which contributions are not due, but the State is liable for contributions for another period, we credit the amount paid against the amount of contributions for which the State is liable. We refund any balance to the State.

§404.1282 Time limitations on credits or refunds—for wages paid prior to 1987.

(a) *General.* To get a credit or refund, a State must file a claim for a credit or refund of the overpaid amount with the Commissioner before the applicable time limitation expires. The State's claim for credit or refund is considered filed with the Commissioner when it is delivered or mailed to the Commissioner. Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, we consider a claim timely filed if it is filed on the next Federal workday.

(b) *Time limitation.* Subject to the exceptions in §404.1283, a State must file a claim for credit or refund of an overpayment before the end of the latest of the following time periods:

(1) 3 years, 3 months, and 15 days after the year in which the wages in question were paid or alleged to have been paid; or

(2) 3 years after the due date of the payment which included the overpayment; or

(3) 2 years after the overpayment was made to the Secretary of the Treasury.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1283 Exceptions to the time limitations on credits or refunds—for wages paid prior to 1987.

(a)(1) *Extension by agreement.* The applicable time period described in § 404.1282 for filing a claim for credit for, or refund of, an overpayment may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Commissioner. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s) and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Commissioner. (See § 404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) A claim for credit or refund filed by the State before the extended time limit ends shall be considered to have been filed within the time period limitation specified in section 218(r)(1) of the Act as it read prior to the enactment of Pub. L. 99–509. (See § 404.1282.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Commissioner for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under §§ 404.1290 or 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *Deletion of wage entry on employee's earnings record.* If the Commissioner, under section 205(c)(5) (A), (B), or (E) of the Act, deletes a wage entry on an individual's earnings record, a claim for credit or refund of the overpayment resulting from the deletion is considered filed within the applicable time limitations in § 404.1282 if

(1) The State files the claim before the Commissioner's decision regarding the deletion of the wage entry from the individual's earnings record becomes final or

(2) The State files a claim regarding the deletion of the wage entry from the individual's earnings record which entry is erroneous because of fraud.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1284 Offsetting underpayments against overpayments—for wages paid prior to 1987.

(a) *State fails to make adjustment for allowance of credit.* If SSA notifies a State that a credit is due the State, and the State does not make the adjustment for the allowance of the credit, SSA offsets the credit against any contributions or interest due. Before making the offset, SSA will give the State an opportunity to make the adjustment.

(b) *State fails to make adjustment for underpayment of contributions or interest due.* If SSA notifies a State that contributions or interest are due, and the State does not pay the contributions or interest, SSA offsets the contributions or interest due against any credit due the State. Before making the offset, SSA will give the State an opportunity to pay the underpayment or interest due.

HOW ASSESSMENTS FOR UNDERPAYMENTS OF CONTRIBUTIONS ARE MADE—FOR WAGES PAID PRIOR TO 1987

§ 404.1285 Assessments of amounts due—for wages paid prior to 1987.

(a) A State is liable for any amount due (which includes contributions or interest) under an agreement until the Commissioner is satisfied that the amount has been paid to the Secretary of the Treasury. If the Commissioner is not satisfied that a State has paid the amount due, the Commissioner issues an assessment for the amount due subject to the time limitations in § 404.1286 and the exceptions to the time limitations in §§ 404.1287 and 404.1289. If detailed wage information is not available, the assessment is issued based on the following:

(1) The largest number of individuals whose services are known to be covered under the agreement is used for computation purposes;

(2) The individuals are assumed to have maximum creditable earnings each year;

(3) The earnings are considered wages for covered services; and

(4) The amount computed is increased by twenty percent to insure that all covered wages are included in the assessment.

(b) If the State pays the amount assessed and the assessed amount is later determined to be more than the amount actually due, we issue a refund or credit to that State for the excess amount. When the assessment is issued within the applicable time limitation, there is no time limit on collecting the amount due. An assessment is issued on the date that it is mailed or otherwise delivered to the State.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1286 Time limitations on assessments—for wages paid prior to 1987.

(a) Subject to the exceptions to the time limitations in §§ 404.1287 and 404.1289, a State is not liable for an amount due under an agreement unless the Commissioner makes an assessment for that amount before the later of the following periods ends:

(1) Three years, 3 months, and 15 days after the year in which the wages, upon which the amount is due, were paid; or

(2) Three years after the date the amount became due.

(b) Where the time limitation ends on a weekend, legal holiday or Federal nonworkday, an assessment is considered timely if the Commissioner makes the assessment on the next Federal workday.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1287 Exceptions to the time limitations on assessments—for wages paid prior to 1987.

(a)(1) *Extension by agreement.* The applicable time period described in § 404.1286 for assessment of an amount due may, before the expiration of such period, be extended for no more than 6 months by written agreement between the State and the Commissioner. The agreement must involve and identify a known issue or reporting error. It must also identify the periods involved, the time limitation which is being extended and the date to which it is being extended, and the coverage group(s) and position(s) or individual(s) to which the agreement applies. The extension of the period of limitation shall not become effective until the agreement is signed by the appropriate State official and the Commissioner. (See § 404.3(c) for the applicable rule where periods of limitation expire on nonwork days.) An assessment made by the Commissioner before the extended time limit ends shall be considered to have been made within the time period limitation specified in section 218(q)(2) of the Act as it read prior to the enactment of Pub. L. 99–509. (See § 404.1286.)

(2) *Reextension.* An extension agreement provided for in paragraph (a)(1) of this section may be reextended by written agreement between the State and the Commissioner for no more than 6 months at a time beyond the expiration of the prior extension or reextension agreement, and only if one of the following conditions is met:

(i) Litigation (including intrastate litigation) or a review under § 404.1290 or § 404.1297 involving wage reports or corrections on the same issue is pending; or

(ii) The State is actively pursuing corrections of a known error which require additional time to complete; or

(iii) The Social Security Administration is developing a coverage or wage issue which was being considered before the statute of limitations expired and additional time is needed to make a determination; or

(iv) The Social Security Administration has not issued to the State a final audit statement on the State's wage or correction reports; or

(v) There is pending Federal legislation which may substantially affect the issue in question, or the issue has national implications.

(b) *The 365-day period.* If a State files a report before the applicable time limitation in § 404.1286 (or any extension under paragraph (a) of this section) ends and makes no payment or pays less than the correct amount due, the Commissioner may assess the State for the amount due after the applicable time limitation has ended. However, the Commissioner must make the assessment no later than the 365th day after the day the State makes payment to the Secretary of the Treasury. The Commissioner can only make this assessment on the wages paid to the reported individuals for the reported periods. The Commissioner, in making this assessment, credits the amount paid by the State on these individuals' wages for those reported periods.

(c) *Revision of employee's earnings record.* If, under section 205(c)(5) (A) or (B) of the Act, the Commissioner credits wages to an individual's earnings record, the Commissioner may make an assessment for any amount due on those wages before the Commissioner's decision on revising the individual's earnings record becomes final. (Sections 404.822(c) (1) and (2) describe the time limits for revising an earnings record where an individual has applied for monthly benefits or a lump-sum death payment or requested that we correct his earnings record.)

(d) *Overpayment of contributions on wages of employee having other wages in a period barred to assessment.* If the Commissioner allows a State a credit or refund of an overpayment for wages paid or alleged to have been paid an individual in a calendar year but the facts upon which the allowance is based establish that contributions are due on other wages paid that individual in that year which are barred to assessment, we may make an assessment notwithstanding the periods of limitation in § 404.1286. The assessment, however, must be made before or at the time we notify the State of the allowance of the credit or refund. In this situation, the Commissioner reduces the amount of the State's credit or refund by the assessed amount and notifies the State accordingly. For purposes of this paragraph, the assessment shall only include contributions and not interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

Example: The State files an adjustment report timely to correct an error in the amount reported as wages for an employee. The correction reduces the employee's wages for the year to less than the maximum amount creditable. The employee has other earnings in the same year which were not reported because of the previously reported maximum amounts. The applicable time limitation for assessing contributions on wages for the year has expired before the credit was allowed. The Commissioner may assess for the underpaid contributions but no later than thd date of the notice to the State that its claim for a credit had been allowed.

(e) *Evasion of payment.* The Commissioner may make an assessment of an amount due at any time where the State's failure to pay the amount due results from the fraudulent attempt of an officer or employee of the State or political subdivision to defeat or evade payment of that amount.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1289 Payment after expiration of time limitation for assessment—for wages paid prior to 1987.

The Commissioner accepts wage reports filed by a State even though the applicable time limitation described in § 404.1286 (or as the time limitation is extended under § 404.1287) has expired, provided:

(a) The State pays to the Secretary of the Treasury the amount due on the wages paid to employees performing services in the coverage group in the calendar years for which the wage reports are being made; and

(b) The State agrees in writing with the Secretary to extend the time limitation for all employees in the coverage group in the calendar years for which the wage reports are being made. In this situation, the time period for assessment is extended until the Commissioner notifies the State that the wage reports are accepted. Where the State pays the amount due within the time period as extended under this section, the amount shall not include interest as provided for in section 218(j) of the Act as it read prior to the enactment of Pub. L. 99–509.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

SECRETARY'S REVIEW OF DECISIONS ON CREDITS, REFUNDS, OR ASSESSMENTS—FOR WAGES PAID PRIOR TO 1987

§404.1290 Review of decisions by the Secretary—for wages paid prior to 1987.

What decisions will be reviewed. A State, under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509, may request review of an assessment of an amount due from the State, an allowance to the State of a credit or refund of an overpayment, or a disallowance of the State's claim for credit or refund of an overpayment. The Commissioner may review regardless of whether the amount assessed has been paid or whether the credit or refund has been accepted by the State. Prior to the Commissioner's review, however, an assessment, allowance or disallowance may be reconsidered under §§404.1291 through 404.1293.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§404.1291 Reconsideration—for wages paid prior to 1987.

After the State requests review of the assessment or allowance or disallowance of a credit or refund, and prior to the Commissioner's review, that decision may be reconsidered, and affirmed, modified, or reversed. We notify the State of the reconsidered determination and the basis for it. The State may request the Commissioner to review this reconsidered determination under §404.1294(b). In limited situations, SSA and the State may agree that the reconsideration process should be waived, e.g., where major policy is at issue.

§404.1292 How to request review—for wages paid prior to 1987.

(a) *Form of request.* No particular form of request is required. However, a written request for review must:

(1) Identify the assessment, allowance or disallowance being questioned;

(2) Describe the specific issue on which the review is requested;

(3) Contain any additional information or argument relevant to that issue; and

(4) Be signed by an official authorized to request the review on behalf of the State.

(b) *Submitting additional material.* A State has 90 days from the date it requests review to submit additional evidence it wishes considered during the review process. The time limit for submitting additional evidence may be extended upon written request of the State and for good cause shown.

§404.1293 Time for filing request for review—for wages paid prior to 1987.

(a) *Time for filing.* The State must file its request for review within 90 days after the date of the notice of assessment, allowance, or disallowance. Usually, the date of the request for review is considered the filing date. Where the 90-day period ends on a weekend, legal holiday or Federal nonworkday, a request filed on the next Federal workday is considered as timely filed.

(b) *Extension of time.* For good cause shown, and upon written application by a State filed prior to the expiration of the time for filing a request for review, additional time for filing the request may be allowed.

§404.1294 Notification to State after reconsideration—for wages paid prior to 1987.

(a) The State will be notified in writing of the reconsidered determination on the assessment, allowance, or disallowance, and the basis for the determination.

(b) If the State does not agree with the reconsidered determination, it has 90 days from the date of notice of the

reconsidered determination to request the Commissioner to review that determination. The rules on what the request should contain and the time for filing the request are the same as in §§ 404.1292 and 404.1293.

§ 404.1295 Commissioner's review—for wages paid prior to 1987.

Upon request by the State, the Commissioner will review the reconsidered determination (or the assessment, allowance or disallowance as initially issued if reconsideration is waived under § 404.1291). If necessary, the Commissioner may request the State to furnish additional evidence. Based upon the evidence considered in connection with the assessment, allowance or disallowance and any additional evidence submitted by the State or otherwise obtained by the Commissioner, the Commissioner affirms, modifies, or reverses the assessment, allowance or disallowance.

§ 404.1296 Commissioner's notification to the State—for wages paid prior to 1987.

The Commissioner notifies the State in writing of the decision on the assessment, allowance, or disallowance, and the basis for the decision.

HOW A STATE MAY SEEK COURT REVIEW OF COMMISSIONER'S DECISION—FOR WAGES PAID PRIOR TO 1987

§ 404.1297 Review by court—for wages paid prior to 1987.

(a) *Who can file civil action in court.* A State may file a civil action under section 218(t) of the Act as it read prior to the enactment of Pub. L. 99–509 requesting a district court of the United States to review any decision the Commissioner makes under section 218(s) of the Act as it read prior to the enactment of Pub. L. 99–509 concerning the assessment of an amount due, the allowance of a credit or refund, or the disallowance of a claim for credit or refund.

(b) *Where the civil action must be filed.* A State must file the civil action in the district court of the United States for the judicial district in which the State's capital is located. If the civil action is brought by an interstate instrumentality, it must file the civil action in the district court of the United States for the judicial district in which the instrumentality's principal office is located. The district court's judgment is final except that it is subject to review in the same manner as judgments of the court in other civil actions.

(c) *No interest on credit or refund of overpayment.* SSA has no authority to pay interest to a State after final judgment of a court involving a credit or refund of an overpayment made under section 218 of the Act.

[53 FR 32976, Aug. 29, 1988, as amended at 62 FR 38451, July 18, 1997]

§ 404.1298 Time for filing civil action—for wages paid prior to 1987.

(a) *Time for filing.* The State must file the civil action for a redetermination of the correctness of the assessment, allowance or disallowance within 2 years from the date the Commissioner mails to the State the notice of the decision under § 404.1296. Where the 2-year period ends on a Saturday, Sunday, legal holiday or Federal nonwork day, an action filed on the next Federal workday is considered timely filed.

(b) *Extension of time for filing.* The Commissioner, for good cause shown, may upon written application by a State filed prior to the end of the two-year period, extend the time for filing the civil action.

§ 404.1299 Final judgments—for wages paid prior to 1987.

(a) *Overpayments.* Payment of amounts due to a State required as the result of a final judgment of the court shall be adjusted under §§ 404.1271 and 404.1272.

(b) *Underpayments.* Wage reports and contribution returns required as the result of a final judgment of the court shall be filed under §§ 404.1237–404.1251. We will assess interest under § 404.1265 where, based upon a final judgment of the court, contributions are due from a State because the amount of contributions assessed was not paid by the State or the State had used an allowance of a credit or refund of an overpayment.

Subpart N—Wage Credits for Veterans and Members of the Uniformed Services

AUTHORITY: Secs. 205 (a) and (p), 210 (l) and (m), 215(h), 217, 229, and 702(a)(5) of the Social Security Act (42 U.S.C. 405 (a) and (p), 410 (l) and (m), 415(h), 417, 429, and 902(a)(5)).

SOURCE: 45 FR 16464, Mar. 14, 1980, unless otherwise noted.

GENERAL

§404.1301 Introduction.

(a) The Social Security Act (Act), under section 217, provides for noncontributory wage credits to veterans who served in the active military or naval service of the United States from September 16, 1940, through December 31, 1956. These individuals are considered World War II or post-World War II veterans. The Act also provides for noncontributory wage credits to certain individuals who served in the active military or naval service of an allied country during World War II. These individuals are considered World War II veterans. In addition, certain individuals get wage credits, under section 229 of the Act, for service as members of the uniformed services on active duty or active duty for training beginning in 1957 when that service was first covered for social security purposes on a contributory basis. These individuals are considered members of the uniformed services.

(b) World War II or post-World War II veterans receive wage credits based on the length of active military or naval service, type of separation from service and, in some cases, whether the veteran is receiving another Federal benefit. However, a member of a uniformed service receives wage credits regardless of length of service, type of separation, or receipt of another Federal benefit.

(c) The Social Security Administration (SSA) uses these wage credits, along with any covered wages or self-employment income of the veteran or member of a uniformed service, to determine entitlement to, and the amount of, benefits and the lump-sum death payment that may be paid to them, their dependents or survivors under the old-age, survivors', and disability insurance programs. These wage credits can also be used by the veteran or member of the uniformed service to meet the insured status and quarters of coverage requirements for a period of disability.

(d) This subpart tells how veterans or members of the uniformed services obtain wage credits, what evidence of service SSA requires, how SSA uses the wage credits, and how the wage credits are affected by payment of other benefits.

(e) This subpart explains that certain World War II veterans who die are considered (deemed) fully insured. This gives those veterans' survivors the same benefit rights as if the veterans were actually fully insured when they died.

(f) The rules are organized in the following manner:

(1) Sections 404.1310 through 404.1313 contain the rules on World War II veterans. We discuss who may qualify as a World War II veteran, how we determine whether the 90-day active service requirement for a World War II veteran is met, what we consider to be World War II active military or naval service, and what we do not consider to be World War II active military or naval service.

(2) Sections 404.1320 through 404.1323 contain the rules on post-World War II veterans. We discuss who may qualify as a post-World War II veteran, how we determine whether the 90-day active service requirement for a post-World War II veteran is met, what we consider to be post-World War II active military or naval service, and what we do not consider to be post-World War II active military or naval service.

(3) In §404.1325 we discuss what is a *separation under conditions other than dishonorable.* The law requires that a World War II or post-World War II veteran's separation from active military or naval service be other than dishonorable for the veteran to get wage credits.

(4) Section 404.1330 contains the rules on members of the uniformed services. We discuss who may qualify as a member of a uniformed service.

(5) In §§404.1340 through 404.1343, we discuss the amount of wage credits for veterans and members of the uniformed services, situations which may limit

the use of wage credits for World War II and post-World War II veterans, and situations in which the limits do not apply.

(6) Sections 404.1350 through 404.1352 contain the rules on deemed insured status for World War II veterans. We discuss when deemed insured status applies, the amount of wage credits used for deemed insured World War II veterans, how the wage credits affect survivors' social security benefits, and when deemed insured status does not apply.

(7) Sections 404.1360 through 404.1363 contain the rules on the effect of other benefits on the payment of social security benefits and lump-sum death payments based on wage credits for veterans. We discuss what happens when we learn of a determination that a Veterans Administration pension or compensation is payable or that a Federal benefit is payable before or after we determine entitlement to a montly benefit or lump-sum death payment based on the death of the veteran.

(8) Sections 404.1370 and 404.1371 contain the rules on what we accept as evidence of a World War II and post-World War II veteran's active military or naval service, including date and type of separation, and what we accept as evidence of entitlement to wage credits for membership in a uniformed service during the years 1957 through 1967.

§ 404.1302 Definitions.

As used in this subpart—

Act means the Social Security Act, as amended.

Active duty means periods of time an individual is on full-time duty in the active military or naval service after 1956 and includes active duty for training after 1956.

Active service means periods of time prior to 1957 an individual was on full-time duty in the active military or naval service. It does not include totaling periods of active duty for training purposes before 1957 which are less than 90 days.

Allied country means a country at war on September 16, 1940, with a country with which the United States was at war during the World War II period. Each of the following countries is considered an allied country: Australia, Belgium, Canada, Czechoslovakia, Denmark, France, India, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Union of South Africa, and the United Kingdom.

Domiciled in the United States means an individual has a true, fixed, and permanent home in the United States to which the individual intends to return whenever he or she is absent.

Federal benefit means a benefit which is payable by another Federal agency (other than the Veterans Administration) or an instrumentality owned entirely by the United States under any law of the United States or under a program or pension system set up by the agency or instrumentality.

Post-World War II period means the time period July 25, 1947, through December 31, 1956.

Reserve component means Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve, Coast Guard Reserve, National Guard of the United States or Air National Guard of the United States.

Resided in the United States means an individual had a place where he or she lived, whether permanently or temporarily, in the United States and was bodily present in that place.

Survivor means you are a parent, widow, divorced wife, widower, or child of a deceased veteran or member of a uniformed service.

United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

Veteran means an individual who served in the active military or naval service of the United States and was discharged or released from that service under conditions other than dishonorable. For a more detailed definition of the World War II veteran and a post-World War II veteran, see §§ 404.1310 and 404.1320.

Wage credit means a dollar amount we add to the earnings record of a veteran of the World War II or the post-World War II period. It is also a dollar amount we add to the earnings record of a member of a uniformed service who was on active duty after 1956. The amount is set out in the Act and is

added for each month, calendar quarter, or calendar year of service as required by law.

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

World War II period means the time period September 16, 1940, through July 24, 1947.

You or *your* means a veteran, a veteran's survivor or a member of a uniformed service applying for or entitled to a social security benefit or a lump-sum death payment.

WORLD WAR II VETERANS

§404.1310 Who is a World War II veteran.

You are a World War II veteran if you were in the active service of the United States during the World War II period and, if no longer in active service, you were separated from that service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in §404.1311.

§404.1311 Ninety-day active service requirement for World War II veterans.

(a) The 90 days of active service required for World War II veterans do not have to be consecutive if the 90 days were in the World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes which were less than 90 days.

(b) If, however, all of the 90 days of active service required for World War II veterans were not in the World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before September 16, 1940, and ended on or after that date, or began before July 25, 1947, and ended on or after that date.

(c) The 90 days of active service is not required if the World War II veteran died in service or was separated from service under conditions other than dishonorable because of a disability or injury which began or worsened while performing service duties.

§404.1312 World War II service included.

Your service was in the active service of the United States during the World War II period if you were in the—

(a) Army, Navy, Marine Corps, or Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were—

(1) On active commissioned service during the period beginning September 16, 1940, through July 28, 1945, and the active service was done while on detail to the Army, Navy, Marine Corps, or Coast Guard; or

(2) On active commissioned service during the period beginning July 29, 1945, through July 24, 1947, regardless of whether on detail to the Army, Navy, Marine Corps, or Coast Guard;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were—

(1) During the World War II period—

(i) Transferred to active service with the Army, Navy, Marine Corps, or Coast Guard; or

(ii) Assigned to active service on military projects in areas determined by the Secretary of Defense to be areas of immediate military hazard; or

(2) On active service in the Philippine Islands on December 7, 1941; or

(3) On active service during the period beginning July 29, 1945, through July 24, 1947;

(d) Philippine Scouts and performed active service during the World War II period under the direct supervision of recognized military authority;

(e) Active service of an allied country during the World War II period and—

(1) Had entered into that active service before December 9, 1941;

(2) Were a citizen of the United States throughout that period of active service or lost your United States citizenship solely because of your entrance into that service;

(3) Had resided in the United States for a total of four years during the five-year period ending on the day you entered that active service; and

(4) Were domiciled in the United States on that day; or

(f) Women's Army Auxiliary Corps, during the period May 14, 1942, through September 29, 1943, and performed active service with the Army, Navy, Marine Corps, or Coast Guard after September 29, 1943.

§ 404.1313 World War II service excluded.

Your service was not in the active service of the United States during the World War II period if, for example, you were in the—

(a) Women's Army Auxiliary Corps, except as described in § 404.1312(f);

(b) Coast Guard Auxiliary;

(c) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(d) Civil Air Patrol; or

(e) Civilian Auxiliary to the Military Police.

POST-WORLD WAR II VETERANS

§ 404.1320 Who is a post-World War II veteran.

You are a post-World War II veteran if you were in the active service of the United States during the post-World War II period and, if no longer in active service, you were separated from the service under conditions other than dishonorable after at least 90 days of active service. The 90-day active service requirement is discussed in § 404.1321.

§ 404.1321 Ninety-day active service requirement for post-World War II veterans.

(a) The 90 days of active service required for post-World War II veterans do not have to be consecutive if the 90 days were in the post-World War II period. The 90-day requirement cannot be met by totaling the periods of active duty for training purposes before 1957 which were less than 90 days.

(b) If, however, all of the 90 days of active service required for post-World War II veterans were not in the post-World War II period, the 90 days must (only in those circumstances) be consecutive if the 90 days began before July 25, 1947, and ended on or after that date, or began before January 1, 1957, and ended on or after that date.

(c) The 90 days of active service is not required if the post-World War II veteran died in service or was separated from service under conditions other than dishonorable because of a disability or injury which began or worsened while performing service duties.

§ 404.1322 Post-World War II service included.

Your service was in the active service of the United States during the post-World War II period if you were in the—

(a) Air Force, Army, Navy, Marine Corps, Coast Guard, or any part of them;

(b) Commissioned corps of the United States Public Health Service and were on active service during that period;

(c) Commissioned corps of the United States Coast and Geodetic Survey and were on active service during that period; or

(d) Philippine Scouts and performed active service during the post-World War II period under the direct supervision of recognized military authority.

§ 404.1323 Post-World War II service excluded.

Your service was not in the active service of the United States during the post-World War II period if, for example, you were in the—

(a) Coast Guard Auxiliary;

(b) Coast Guard Reserve (Temporary) unless you served on active full-time service with military pay and allowances;

(c) Civil Air Patrol; or

(d) Civilian Auxiliary to the Military Police.

SEPARATION FROM ACTIVE SERVICE

§ 404.1325 Separation from active service under conditions other than dishonorable.

Separation from active service under conditions other than dishonorable means any discharge or release from the active service except—

(a) A discharge or release for desertion, absence without leave, or fraudulent entry;

(b) A dishonorable or bad conduct discharge issued by a general court

martial of the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States, or by the active service of an allied country during the World War II period;

(c) A dishonorable discharge issued by the United States Public Health Service or the United States Coast and Geodetic Survey;

(d) A resignation by an officer for the good of the service;

(e) A discharge or release because the individual was a conscientious objector; or

(f) A discharge or release because the individual was convicted by a civil court for treason, sabotage, espionage, murder, rape, arson, burglary, robbery, kidnapping, assault with intent to kill, assault with a deadly weapon, or because of an attempt to commit any of these crimes.

[45 FR 16464, Mar. 14, 1980; 45 FR 22023, Apr. 3, 1980]

MEMBERS OF THE UNIFORMED SERVICES

§404.1330 Who is a member of a uniformed service.

A member of a uniformed service is an individual who served on active duty after 1956. You are a member of a uniformed service if you—

(a) Are appointed, enlisted, or inducted into—

(1) The Air Force, Army, Navy, Coast Guard, or Marine Corps; or

(2) A reserve component of the uniformed services in paragraph (a)(1) of this section (except the Coast Guard Reserve as a temporary member);

(b) Served in the Army or Air Force under call or conscription;

(c) Are a commissioned officer of the National Oceanic and Atmospheric Administration or its predecessors, the Environmental Science Services Administration and the Coast and Geodetic Survey;

(d) Are a commissioned officer of the Regular or Reserve Corps of the Public Health Service;

(e) Are a retired member of any of the above services;

(f) Are a member of the Fleet Reserve or Fleet Marine Corps Reserve;

(g) Are a cadet at the United States Military Academy, Air Force Academy, or Coast Guard Academy, or a midshipman at the United States Naval Academy; or

(h) Are a member of the Reserve Officers Training Corps of the Army, Navy or Air Force, when ordered to annual training duty for at least 14 days and while performing official travel to and from that duty.

AMOUNTS OF WAGE CREDITS AND LIMITS ON THEIR USE

§404.1340 Wage credits for World War II and post-World War II veterans.

In determining your entitlement to, and the amount of, your monthly benefit or lump-sum death payment based on your active service during the World War II period or the post-World War II period, and for establishing a period of disability as discussed in §§404.132 and 404.133, we add the (deemed) amount of $160 for each month during a part of which you were in the active service as described in §404.1312 or §404.1322. For example, if you were in active service from October 11, 1942, through August 10, 1943, we add the (deemed) amount of $160 for October 1942 and August 1943 as well as November 1942 through July 1943. The amount of wage credits that are added in a calendar year cannot cause the total amount credited to your earnings record to exceed the annual earnings limitation explained in §§404.1047 and 404.1096(b).

§404.1341 Wage credits for a member of a uniformed service.

(a) *General.* In determining your entitlement to, and the amount of your monthly benefit (or lump sum death payment) based on your wages while on active duty as a member of the uniformed service after 1956, and for establishing a period of disability as discussed in §404.132, we add wage credits to the wages paid you as a member of that service. The amount of the wage credits, the applicable time periods, the wage credit amount limits, and the requirement of a minimum period of active duty service for granting these wage credits, are discussed in paragraphs (b), (c), and (d) of this section.

(b) *Amount of wage credits.* The amount of wage credits added is—

(1) $100 for each $300 in wages paid to you for your service in each calender year after 1977; and

(2) $300 for each calendar quarter in 1957 through 1977, regardless of the amount of wages actually paid you during that quarter for your service.

(c) *Limits on wage credits.* The amount of these wage credits cannot exceed—

(1) $1200 for any calendar year, or

(2) An amount which when added to other earnings causes the total earnings for the year to exceed the annual earnings limitation explained in §§ 404.1047 and 404.1096(b).

(d) *Minimum active-duty service requirement.* (1) If you enlisted for the first time in a regular component of the Armed Forces on or after September 8, 1980, you must complete the shorter of 24 months of continuous active duty or the full period that you were called to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.;

(iv) You die during your period of enlistment; or

(v) You were discharged prior to October 14, 1982, and your discharge was—

(A) Under chapter 61 of title 10 U.S.C.; or

(B) Because of a disability which resulted from an injury or disease incurred in or aggravated during your enlistment which was not the result of your intentional misconduct and did not occur during a period of unauthorized absence.

(2) If you entered on active duty as a member of the uniformed services as defined in § 404.1330 *on or after* October 14, 1982, having neither previously completed a period of 24 months' active duty nor been discharged or released from this period of active duty under section 1171, title 10 U.S.C. (i.e., convenience of the government), you must complete the shorter of 24 months of continuous active duty or the full period you were called or ordered to active duty to receive these wage credits, unless:

(i) You are discharged or released from active duty for the convenience of the government in accordance with section 1171 of title 10 U.S.C. or because of hardship as specified in section 1173 of title 10 U.S.C.;

(ii) You are discharged or released from active duty for a disability incurred or aggravated in line of duty;

(iii) You are entitled to compensation for service-connected disability or death under chapter 11 of title 38 U.S.C.; or

(iv) You die during your period of active service.

[45 FR 16464, Mar. 14, 1980, as amended at 52 FR 29663, Aug. 11, 1987]

§ 404.1342 Limits on granting World War II and post-World War II wage credits.

(a) You get wage credits for World War II or post-World War II active service only if the use of the wage credits results in entitlement to a monthly benefit, a higher monthly benefit, or a lump-sum death payment.

(b) You may get wage credits for active service in July 1947 for either the World War II period or the post-World War II period but not for both. If your active service is before and on or after July 25, 1947, we add the $160 wage credit to the period which is most advantageous to you.

(c) You do not get wage credits for the World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you, even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the World War II period except as explained in § 404.1343.

(d) You do not get wage credits for the post-World War II period if another Federal benefit (other than one payable by the Veterans Administration) is determined by a Federal agency or an instrumentality owned entirely by the United States to be payable to you,

even though the Federal benefit is not actually paid or is paid and then terminated, based in part on your active service during the post-World War II period except as explained in §404.1343.

§404.1343 When the limits on granting World War II and post-World War II wage credits do not apply.

The limits on granting wage credits described in §404.1342 (c) and (d) do not apply—

(a) If the wage credits are used solely to meet the insured status and quarters of coverage requirements for a period of disability as described in §§404.132 and 404.133;

(b) If you are the surviving spouse or child of a veteran of the World War II period or post-World War II period and you are entitled under the Civil Service Retirement Act of 1930 to a survivor's annuity based on the veteran's active service and—

(1) You give up your right to receive the survivor's annuity;

(2) A benefit under the Civil Service Retirement Act of 1930 based on the veteran's active service was not payable to the veteran; and

(3) Another Federal benefit is not payable to the veteran or his or her survivors except as described in paragraph (c) of this section; or

(c) For the years 1951 through 1956, if another Federal benefit is payable by the Army, Navy, Air Force, Marine Corps, Coast Guard, Coast and Geodetic Survey, or the Public Health Service based on post-World War II active service but only if the veteran was also paid wages as a member of a uniformed service after 1956.

[45 FR 16464, Mar. 14, 1980, as amended at 49 FR 24118, June 12, 1984]

DEEMED INSURED STATUS FOR WORLD II VETERANS

§404.1350 Deemed insured status.

(a) *When deemed insured status applies.* If you are the survivor of a World War II veteran, we consider the veteran to have died fully insured as discussed in §404.111 and we include wage credits in determining your monthly benefit or lump-sum death payment if—

(1) The veteran was separated from active service of the United States before July 27, 1951; and

(2) The veteran died within 3 years after separation from active service and before July 27, 1954.

(b) *Amount of credit given for deemed insured World War II veterans.* (1) When we compute a survivor's benefit or lump-sum death payment, we give credit for—

(i) $200 (for increment year purposes) for each calendar year in which the veteran had at least 30 days of active service beginning September 16, 1940, through 1950; and

(ii) An average monthly wage of $160.

(2) If the World War II veteran was fully or currently insured without the wage credits, we add increment years (years after 1936 and prior to 1951 in which the veteran had at least $200 in creditable earnings) to the increment years based on the veteran's wages.

§404.1351 When deemed insured status does not apply.

As a survivor of a World War II veteran, you cannot get a monthly benefit or lump-sum death payment based on the veteran's deemed insured status as explained in §404.1350 if—

(a) Your monthly benefit or lump-sum death payment is larger without using the wage credits;

(b) The Veterans Administration has determined that a pension or compensation is payable to you based on the veteran's death;

(c) The veteran died while in the active service of the United States;

(d) The veteran was first separated from active service after July 26, 1951;

(e) The veteran died after July 26, 1954; or

(f) The veteran's only service during the World War II period was by enlistment in the Philippine Scouts as authorized by the Armed Forces Voluntary Recruitment Act of 1945 (Pub. L. 190 of the 79th Congress).

§404.1352 Benefits and payments based on deemed insured status.

(a) *Our determination.* We determine your monthly benefit or lump-sum death payment under the deemed insured status provisions in §§404.1350 and 404.1351 regardless of whether the

Veterans Administration has determined that any pension or compensation is payable to you.

(b) *Certification for payment.* If we determine that you can be paid a monthly benefit or lump-sum death payment, we certify these benefits for payment. However, the amount of your monthly benefit or lump-sum death payment may be changed if we are informed by the Veterans Administration that a pension or compensation is payable because of the veteran's death as explained in § 404.1360.

(c) *Payments not considered as pension or compensation.* We do not consider as pension or compensation—

(1) National Service Life Insurance payments;

(2) United States Government Life Insurance payments; or

(3) Burial allowance payments made by the Veterans Administration.

EFFECT OF OTHER BENEFITS ON PAYMENT OF SOCIAL SECURITY BENEFITS AND PAYMENTS

§ 404.1360 Veterans Administration pension or compensation payable.

(a) *Before we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you before we determine and certify payment of benefits based on deemed insured status, we compute your monthly benefit or lump-sum death payment based on the death of the World War II veteran without using the wage credits discussed in § 404.1350.

(b) *After we determine and certify payment.* If we are informed by the Veterans Administration that a pension or compensation is payable to you after we determine and certify payment of benefits based on deemed insured status, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§ 404.1361 Federal benefit payable other than by Veterans Administration.

(a) *Before we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service before we determine and certify your monthly benefit or lump-sum death payment, we compute your monthly benefit or lump-sum death payment without using the wage credits discussed in § 404.1340.

(b) *After we determine and certify payment.* If we are informed by another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service after we determine and certify payment, we—

(1) Stop payment of your benefits or recompute the amount of any further benefits that can be paid to you; and

(2) Determine whether you were erroneously paid and the amount of any erroneous payment.

§ 404.1362 Treatment of social security benefits or payments where Veterans Administration pension or compensation payable.

(a) *Before we receive notice from the Veterans Administration.* If we certify your monthly benefit or a lump-sum death payment as determined under the deemed insured status provisions in §404.1350 before we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous only to the extent that they exceed the amount of the accrued pension of compensation payable.

(b) *After we receive notice from the Veterans Administration.* If we certify your monthly benefit or lump-sum death payment as determined under the deemed insured status provisions in § 404.1350 after we receive notice from the Veterans Administration that a pension or compensation is payable to you, our payments to you are erroneous whether or not they exceed the amount of the accrued pension or compensation payable.

§404.1363 Treatment of social security benefits or payments where Federal benefit payable other than by Veterans Administration.

If we certify your monthly benefit or lump-sum death payment based on World War II or post-World War II wage credits after we receive notice from another Federal agency or instrumentality of the United States (other than the Veterans Administration) that a Federal benefit is payable to you by that agency or instrumentality based on the veteran's World War II or post-World War II active service, our payments to you are erroneous to the extent the payments are based on the World War II or post-World War II wage credits. The payments are erroneous beginning with the first month you are eligible for the Federal benefit.

EVIDENCE OF ACTIVE SERVICE AND MEMBERSHIP IN A UNIFORMED SERVICE

§404.1370 Evidence of active service and separation from active service.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the active service of a World War II or post-World War II veteran, you must submit evidence of—

(1) Your entitlement as required by subpart H of this part or other evidence that may be expressly required;

(2) The veteran's period in active service of the United States; and

(3) The veteran's type of separation from active service of the United States.

(b) *Evidence we accept.* We accept as proof of a veteran's active service and separation from active service—

(1) An original certificate of discharge, or an original certificate of service, from the appropriate military service, from the United States Public Health Service, or from the United States Coast and Geodetic Survey;

(2) A certified copy of the original certificate of discharge or service made by the State, county, city agency or department in which the original certificate is recorded;

(3) A certification from the appropriate military service, United States Public Health Service, or United States Coast and Geodetic Survey showing the veteran's period of active service and type of separation;

(4) A certification from a local selective service board showing the veteran's period of active service and type of separation; or

(5) Other evidence that proves the veteran's period of active service and type of separation.

§404.1371 Evidence of membership in a uniformed service during the years 1957 through 1967.

(a) *General.* When you file an application for a monthly benefit or lump-sum death payment based on the services of a member of a uniformed service during the years 1957 through 1967, you should submit evidence identifying the member's uniformed service and showing the period(s) he or she was on active duty during those years.

(b) *Evidence we accept.* The evidence we will accept includes any official correspondence showing the member's status as an active service member during the appropriate period, a certification of service by the uniformed service, official earnings statements, copies of the member's Form W–2, and military orders, for the appropriate period.

Subpart O—Interrelationship of Old-Age, Survivors and Disability Insurance Program With the Railroad Retirement Program

AUTHORITY: Secs. 202(l), 205(a), (c)(5)(D), (i), and (o), 210 (a)(9) and (l)(4), 211(c)(3), and 702(a)(5) of the Social Security Act (42 U.S.C. 402(l), 405(a), (c)(5)(D), (i), and (o), 410 (a)(9) and (l)(4), 411(c)(3), and 902(a)(5)).

CROSS REFERENCE: For regulations under the Railroad Retirement Act, see chapter II of this title.

§404.1401 General relationship of Railroad Retirement Act with the old-age, survivors and disability insurance program of the Social Security Act.

The Railroad Retirement Act sets up a system of benefits for railroad employees, their dependents and survivors, and has been integrated with the Social Security Act to provide a coordinated system of retirement, survivor, dependent and disability benefits

payable on the basis of an individual's work in the railroad industry and in employment and self-employment covered by the Social Security Act. With respect to the coordination between the two programs, the Railroad Retirement Act distinguishes between ''career'' railroad workers and those individuals who may be considered ''casual'' railroad workers. The line of demarcation is generally 10 years of service in the railroad industry, including service prior to 1937. The Railroad Retirement Act transfers to the old-age, survivors and disability insurance system the compensation records of individuals who at the time of retirement, onset of disability or death have less than 10 years of service in the railroad industry and meet certain other requirements. Any compensation paid to such individuals for such service after 1936 becomes wages under the Social Security Act (to the extent they do not exceed the annual wage limitations described in § 404.1027(a)). Whatever benefits are payable to them, their dependents, and their survivors are computed on the basis of the combined compensation and social security covered earnings creditable to the individuals' records. The compensation paid to individuals with 10 or more years of railroad service remain under the Railroad Retirement Act, but in certain circumstances, the compensation of such workers who die may be transferred to the old-age, survivors, and disability insurance program (see §§ 404.1402(b) and 404.1407). Under certain circumstances (see § 404.1413), certification of benefits payable under the provisions of the Social Security Act will be made to the Railroad Retirement Board. The Railroad Board will certify such benefits to the Secretary of the Treasury.

[42 FR 18272, Apr. 6. 1977]

§ 404.1402 When services in the railroad industry are covered.

Services performed by an individual in the railroad industry which would, but for the provisions of this section, be excepted from ''employment'' by reason of § 404.1017 shall be considered to be included under ''employment'' as defined in section 210 of the Act in the following situations:

(a) For the purpose of determining entitlement to, or the amount of, any monthly benefits or lump-sum death payment on the basis of the wages and self-employment income of an individual where the years of service in the railroad industry are less than 10;

(b) For the purpose of determining entitlement to, or the amount of, any survivor monthly benefit or any lump-sum death payment on the basis of the wages and self-employment income of an individual whose years of service in the railroad industry were 10 or more but a ''current connection'', as defined in section 1(o) of the Railroad Retirement Act of 1974 (45 U.S.C. 228a), with the railroad industry did not exist at the time of death; (in such cases, survivor benefits are not payable under the Railroad Retirement Act);

(c) For the purpose of determining entitlement to a period of disability (see subpart B of this part) on the basis of the wages and self-employment income of an individual; or

(d) For the purpose of applying the provisions of section 203 of the Act concerning deductions from benefits under the retirement test (see subpart E of this part).

[42 FR 18273, Apr. 6, 1977]

§ 404.1403 Definition of "years of service".

The term *years of service* as used in this subpart has the same meaning as assigned to it by section 1(f) of the Railroad Retirement Act.

[18 FR 8694, Dec. 24, 1953, as amended at 25 FR 5182, June 10, 1960]

§ 404.1404 Effective date of coverage of railroad services under the act.

Coverage under the act of services performed after 1936 by an individual in the railroad industry is effective as follows:

(a) The provisions of paragraphs (a) and (b) of § 404.1402 insofar as they relate to survivor monthly benefits are effective for months after December 1946 and insofar as they relate to lump-sum death payments are effective with respect to deaths after 1946;

(b) The provisions of paragraph (a) of § 404.1402 insofar as they relate to old-

age insurance benefits or monthly benefits of dependents of old-age insurance beneficiaries are effective November 1, 1951; insofar as they relate to disability insurance benefits are effective for months after June 1957; and insofar as they relate to monthly benefits for dependents of disability insurance beneficiaries are effective for months after August 1958;

(c) The provisions of paragraph (c) of §404.1402 are effective for benefits for months after June 1955; and

(d) The provisions of paragraph (d) of §404.1402 are effective November 1, 1951.

[25 FR 5182, June 10, 1960]

§404.1405 When the provisions of §404.1402 do not apply.

(a) *Awards by the Railroad Retirement Board prior to October 30, 1951.* The provisions of §404.1402(a) shall not apply with respect to the wages and self-employment income of an individual if, prior to October 30, 1951, the Railroad Retirement Board has awarded under the Railroad Retirement Act a retirement annuity to such individual or a survivor annuity with respect to the death of such individual and such retirement or survivor annuity, as the case may be, was payable at the time an application for benefits is filed under the Social Security Act on the basis of the wages and self-employment income of such individual. A pension payable under section 6 of the Railroad Retirement Act of 1937 as in effect prior to the Railroad Retirement Act of 1974, or an annuity paid in a lump sum equal to its commuted value under section 3(i) of the Railroad Retirement Act in effect prior to the Social Security Act of October 30, 1951, is not a ''retirement or survivor annuity'' for the purpose of this paragraph.

(b) *Individual continues to work in railroad industry after establishing entitlement to benefits under section 202(a).* An individual's service in the railroad industry used, pursuant to the provisions of §404.1402, to establish entitlement to or to determine the amount of, his old-age insurance benefits under section 202(a) shall not be deemed to be in ''employment'' as defined in section 210 of the Act, if he renders service in the railroad industry after the effective date of such benefits and his years of service attributable thereto when added to his years of service prior to such effective date are 10 or more. Such benefits and any benefits payable to the spouse or child of such individual under section 202(b), (c), or (d) of the Act on the basis of his wages and self-employment income shall be terminated with the month preceding the month in which such individual acquires his tenth year of service. If, however, an insured status (see subpart B of this part) exists without the use of compensation, such benefits shall, in lieu of termination, be recalculated without using such compensation and the recalculated benefits shall be payable with the month in which the tenth year of service was acquired. Any monthly benefits paid prior to such month shall not be deemed erroneous by reason of the use of such compensation.

[18 FR 8694, Dec. 24, 1953, as amended at 25 FR 5182, June 10, 1960; 42 FR 18273, Apr. 6, 1977]

§404.1406 Eligibility to railroad retirement benefits as a bar to payment of social security benefits.

Notwithstanding the fact that, pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are in employment, no lump-sum death payment or survivor monthly benefits shall be paid (except as provided in §404.1407) under the regulations in this part on the basis of such individual's wages and self-employment income if any person, upon filing application therefor, would be entitled to an annuity under section 2 of the Railroad Retirement Act of 1974 or a lump-sum payment under section 6(b) of such Act with respect to the death of that individual; or for periods prior to 1975, would have been entitled to an annuity under section 5 or a lump-sum payment under section 5(f)(1) of the Railroad Retirement Act of 1937 with respect to the death of that individual.

[42 FR 18273, Apr. 6, 1977]

§404.1407 When railroad retirement benefits do not bar payment of social security benefits.

The provisions of §404.1406 shall not operate if:

(a) The survivor is, or upon filing application would be, entitled to a monthly benefit with respect to the death of an insured individual for a month prior to January 1947, if such monthly benefit is greater in amount than the survivor annuity payable to such survivor after 1946 under the Railroad Retirement Act; or

(b) The residual lump-sum payment provided by section 6(c) of the Railroad Retirement Act of 1974 (or section 5(f)(2) of the Railroad Retirement Act of 1937 prior to the 1974 Act) with respect to the death of an insured individual is paid by the Railroad Retirement Board pursuant to an irrevocable election filed with the Board by the widow, widower, or parent of such individual to waive all future annuities or benefits based on the combined record of earnings and compensation to which such widow, widower or parent might become entitled, but only to the extent that widow's, widower's or parent's benefits may be payable under the regulations of this part to such widow, widower or parent, as the case may be, solely on the basis of the wages and self-employment income of such deceased individual and without regard to any compensation which may be treated as wages pursuant to § 404.1408.

[42 FR 18273, Apr. 6, 1977]

§ 404.1408 Compensation to be treated as wages.

(a) *General.* Where pursuant to the preceding provisions of this subpart, services rendered by an individual in the railroad industry are considered to be employment as defined in section 210 of the Social Security Act (see § 404.1027 of this part). Thus, any compensation (as defined in section 1(h) of the Railroad Retirement Act of 1974 or prior to the 1974 Act, section 1(h) of the Railroad Retirement Act of 1937) received by such individual for such services shall constitute wages, provided that the provisions of § 404.1406 do not operate to bar the payments of benefits under title II of the Social Security Act.

(b) *Military Service Exception.* An exception to paragraph (a) of this section applies to any compensation attributable as having been paid during any month on account of military service creditable under section 1 of the Railroad Retirement Act of 1974 (or section 4 of the Railroad Retirement Act of 1937 prior to the 1974 Act). Such compensation shall not constitute wages for purposes of title II of the Social Security Act if, based on such services, wages are deemed to have been paid to such individual during such month under the provisions described in §§ 404.1350 through 404.1352 of this part.

[65 FR 16813, Mar. 30, 2000]

§ 404.1409 Purposes of using compensation.

Compensation which is treated as wages under § 404.1408 shall be used, together with wages (see subpart K of this part) and self-employment income (see subpart K of this part), for purposes of:

(a) Determining an individual's insured status for monthly benefits or the lump-sum death payment (see subpart B of this part);

(b) Computing such individual's primary insurance amount (see subpart C of this part);

(c) Determining an individual's entitlement to the establishment of a period of disability (see subpart B of this part for disability insured status requirements); and

(d) Applying the deduction provisions of section 203 of the act (see subpart E of this part).

[25 FR 5183, June 10, 1960]

§ 404.1410 Presumption on basis of certified compensation record.

(a) *Years prior to 1975.* Where the Railroad Retirement Board certifies to SSA a report of record of compensation, such compensation is treated as wages under § 404.1408. For periods of service which do not identify the months or quarters in which such compensation was paid, the sum of the compensation quarters of coverage (see § 404.1412) will be presumed, in the absence of evidence to the contrary, to represent an equivalent number of quarters of coverage (see § 404.101). No more than four quarters of coverage shall be credited to an individual in a single calendar year.

(b) *Years after 1974.* Compensation paid in a calendar year will, in the absence of evidence to the contrary, be

presumed to have been paid in equal proportions with respect to all months in the year in which the employee will have been in railroad service. (For years prior to 1975, see §404.1412.)

(c) *Allocation of compensation to months of service.* If by means of the presumptions in this section an individual does not have an insured status (see subpart B of this part) on the basis of quarters of coverage with which he is credited, or a deceased individual's primary insurance amount (see §404.201) may be affected because he attained age 22 after 1936, the Administration may request the Railroad Retirement Board to furnish a report of the months in which such individual rendered service for compensation which is treated as wages under §404.1408 if it appears the identification of such months may result in an insured status or if it will affect such primary insurance amount.

(d) *Effect of self-employment income and maximum earnings.* However, if such individual also had self-employment income for a taxable year and the sum of such income and wages (including compensation which is treated as wages under §404.1408) paid to or received by him during such taxable year equals the following amounts, each calendar quarter any part of which falls in such taxable year, shall be a quarter of coverage:

(1) After 1950 and prior to 1955, equals $3,600 of remuneration;

(2) After 1954 and prior to 1959, equals $4,200 of remuneration;

(3) After 1958 and prior to 1966, equals $4,800 of remuneration;

(4) After 1965 and prior to 1968, equals $6,600 of remuneration;

(5) After 1967 and beginning prior to 1972, equals $7,800 of remuneration (including a fiscal year which began in 1971 and ended in 1972);

(6) Beginning after 1971 and prior to 1973, equals $9,000 of remuneration;

(7) Beginning after 1972 and prior to 1974, equals $10,800 of remuneration;

(8) Beginning after 1973 and prior to 1975, equals $13,200 of remuneration;

(9) Beginning after 1974 and prior to 1976, equals $14,100 of remuneration;

(10) Beginning after 1975 and prior to 1977, equals $15,300 of remuneration; or

(11) Beginning after 1976, and amount equal to the contribution and benefit base as determined under section 230 of the Social Security Act which is effective for such calendar year.

This subsection is an exception to the rule in paragraph (a) of this section concerning a presumption applicable to conversion of railroad compensation into quarters of coverage for years prior to 1975.

[42 FR 18273, Apr. 6, 1977, as amended at 65 FR 16814, Mar. 30, 2000]

§404.1412 Compensation quarters of coverage.

As used in this subpart, a compensation quarter of coverage is any quarter of coverage computed with respect to compensation paid to an individual for railroad employment after 1936 and prior to 1975 in accordance with the provisions for determining such quarters of coverage as contained in section 5(l)(4) of the Railroad Retirement Act of 1937. (For years beginning 1975, see §404.1410(b)).

[42 FR 18274, Apr. 6, 1977]

§404.1413 Certification of payment to Railroad Retirement Board.

Certification of benefits shall be made to the Railroad Retirement Board upon final decision of the Commissioner that any person is entitled to any payment or payments under title II and that certification shall include the name and address of the person so entitled to receive such payment or payments, the amount of such payment or payments, and the time at which such payment or payments should be made which shall provide for payment on behalf of the Managing Trustee if:

(a) The claimant will have completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts; or

(b) The claimant is the wife or husband of an individual who has completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts; or

(c) The claimant is the survivor of an individual who had completed 10 years of service under the Railroad Retirement Act of 1937, the Railroad Retirement Act of 1974, or any combination of service under such Acts, if such survivor is entitled, or could upon application be entitled to an annuity under section 2 of the Railroad Retirement Act of 1974; or

(d) The claimant is entitled to benefits under section 202 of the Social Security Act on the basis of the wages and self-employment income of an individual who has 10 years of railroad service (except a survivor of such individual if such individual did not have a *current connection*, as defined in section 1(o) of the Railroad Retirement Act of 1974 (45 U.S.C. 228a) with the railroad industry at the time of his death).

The applicability limitations identified in paragraphs (a) through (d) of this section affects any claimant who first becomes entitled to benefits under title II of the Social Security Act after 1974. (See also § 404.968.)

[42 FR 18274, Apr. 6, 1977, as amended at 62 FR 38451, July 18, 1997]

Subpart P—Determining Disability and Blindness

AUTHORITY: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221 (a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405 (a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104–193, 110 Stat. 2105, 2189.

SOURCE: 45 FR 55584, Aug. 20, 1980, unless otherwise noted.

GENERAL

§ 404.1501 Scope of subpart.

In order for you to become entitled to any benefits based upon disability or blindness or to have a period of disability established, you must be disabled or blind as defined in title II of the Social Security Act. This subpart explains how we determine whether you are disabled or blind. We discuss a *period of disability* in subpart D of this part. We have organized the rules in the following way.

(a) We define general terms, then discuss who makes our disability determinations and state that disability determinations made under other programs are not binding on our determinations.

(b) We explain the term *disability* and note some of the major factors that are considered in determining whether you are disabled in §§ 404.1505 through 404.1510.

(c) Sections 404.1512 through 404.1518 contain our rules on evidence. We explain your responsibilities for submitting evidence of your impairment, state what we consider to be acceptable sources of medical evidence, and describe what information should be included in medical reports.

(d) Our general rules on evaluating disability if you are filing a new application are stated in §§ 404.1520 through 404.1523. We describe the steps that we go through and the order in which they are considered.

(e) Our rules on medical considerations are found in §§ 404.1525 through 404.1530. We explain in these rules—

(1) The purpose of the Listing of Impairments found in appendix 1 of this subpart and how to use it;

(2) What we mean by the term *medical equivalence* and how we determine medical equivalence;

(3) The effect of a conclusion by your physician that you are disabled;

(4) What we mean by symptoms, signs, and laboratory findings;

(5) How we evaluate pain and other symptoms; and

(6) The effect on your benefits if you fail to follow treatment that is expected to restore your ability to work, and how we apply the rule.

(f) In §§ 404.1545 through 404.1546 we explain what we mean by the term *residual functional capacity*, state when an assessment of residual functional capacity is required, and who may make it.

(g) Our rules on vocational considerations are found in §§ 404.1560 through 404.1569a. We explain when vocational factors must be considered along with the medical evidence, discuss the role of residual functional capacity in evaluating your ability to work, discuss the vocational factors of age, education, and work experience, describe what we mean by work which exists in the national economy, discuss the amount of exertion and the type of

skill required for work, describe and tell how to use the Medical-Vocational Guidelines in appendix 2 of this subpart, and explain when, for purposes of applying the guidelines in appendix 2, we consider the limitations or restrictions imposed by your impairment(s) and related symptoms to be exertional, nonexertional, or a combination of both.

(h) Our rules on substantial gainful activity are found in §§404.1571 through 404.1574. These explain what we mean by substantial gainful activity and how we evaluate your work activity.

(i) In §§404.1577, 404.1578, and 404.1579, we explain the special rules covering disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991, and in §§404.1581 through 404.1587 we discuss disability due to blindness.

(j) Our rules on when disability continues and stops are contained in §404.1579 and §§404.1588 through 404.1598. We explain what your responsibilities are in telling us of any events that may cause a change in your disability status, when you may have a trial work period, and when we will review to see if you are still disabled. We also explain how we consider the issue of medical improvement (and the exceptions to medical improvement) in deciding whether you are still disabled.

[45 FR 55584, Aug. 20, 1980, as amended at 50 FR 50126, Dec. 6, 1985; 56 FR 57941, Nov. 14, 1991; 57 FR 30120, July 8, 1992]

§404.1502 General definitions and terms for this subpart.

As used in the subpart—

Acceptable medical source refers to one of the sources described in §404.1513(a) who provides evidence about your impairments. It includes treating sources, nontreating sources, and nonexamining sources.

Commissioner means the Commissioner of Social Security or his or her authorized designee.

Medical sources refers to acceptable medical sources, or other health care providers who are not acceptable medical sources.

Nonexamining source means a physician, psychologist, or other acceptable medical source who has not examined you but provides a medical or other opinion in your case. At the administrative law judge hearing and Appeals Council levels of the administrative review process, it includes State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult. See §404.1527.

Nontreating source means a physician, psychologist, or other acceptable medical source who has examined you but does not have, or did not have, an ongoing treatment relationship with you. The term includes an acceptable medical source who is a consultative examiner for us, when the consultative examiner is not your treating source. See §404.1527.

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, psychologist, or other acceptable medical source who provides you, or 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 an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated 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 or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You or *your* means, as appropriate, the person who applies for benefits or for a period of disability, the person for whom an application is filed, or the person who is receiving benefits based on disability or blindness.

[56 FR 36954, Aug. 1, 1991, as amended at 62 FR 38451, July 18, 1997; 65 FR 11875, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11875, Mar. 7, 2000, § 404.1502 was amended by removing the terms ''Source of record'' and ''You'', by revising the definitions of ''Medical sources'' and ''Treating source'', and by adding definitions for ''Acceptable medical source'', ''Nonexamining source'', ''Nontreating source'', and ''You or your'', effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1502 General definitions and terms for this subpart.

* * * * *

Medical sources refers to treating sources, sources of record, and consultative examiners for us. See § 404.1513.

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.

* * * * *

Treating source means your own physician or psychologist who has provided you with medical treatment or evaluation and who has or has had an ongoing treatment relationship with you. Generally, we will consider that you have an ongoing treatment relationship with a physician or psychologist when the medical evidence establishes that you see or have seen the physician or psychologist with a frequency consistent with accepted medical practice for the type of treatment and evaluation required for your medical condition(s). We may consider a physician or psychologist who has treated you only a few times or only after long intervals (e.g., twice a year) to be your treating source if the nature and frequency of the treatment is typical for your condition(s). We will not consider a physician or psychologist to be your treating physician if your relationship with the physician or psychologist is not based on your need for treatment, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the physician or psychologist to be a consulting physician or psychologist.

* * * * *

You refers to the person who has applied for benefits or for a period of disability or is receiving benefits based on disability or blindness.

DETERMINATIONS

§ 404.1503 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Commissioner 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 Commissioner may take the function away from any State which has substantially failed to make disability and blindness determinations in accordance with these regulations. Subpart Q of this part contains the rules the States must follow in making disability and blindness determinations.

(b) *Social Security Administration.* The Social Security Administration will make disability and blindness determinations for—

(1) Any person living in a State which is not making for the Commissioner 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 Commissioner has authorized the State agencies and the Social Security Administration to make determinations about—

(1) Whether you are disabled or blind;

(2) The date your disability or blindness began; and

(3) The date your disability or blindness stopped.

(d) *Review of State Agency determinations.* On review of a State agency determination or redetermination of disability or blindness we may find that—

(1) You are, or are not, disabled or blind, regardless of what the State agency found;

(2) Your disability or blindness began earlier or later than the date found by the State agency; and

(3) Your disability or blindness stopped earlier or later than the date found by the State agency.

(e) *Initial determinations for mental impairments.* An initial determination by a State agency or the Social Security Administration that you are not disabled (or a Social Security Administration review of a State agency's initial determination), in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See §404.1616 for the qualifications we consider necessary for a psychologist to be a psychological consultant and §404.1617 for what we consider *reasonable effort.*) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Commissioner may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant and not a psychological consultant unless the mental impairment alone would justify a finding of disability.

[46 FR 29204, May 29, 1981, as amended at 52 FR 33926, Sept. 9, 1987; 62 FR 38451, July 18, 1997]

§404.1503a Program integrity.

We will not use in our program any individual or entity, except to provide existing medical evidence, who is currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other Federal or Federally-assisted program; whose license to provide health care services is currently revoked or suspended by any State licensing authority pursuant to adequate due process procedures for reasons bearing on professional competence, professional conduct, or financial integrity; or who, until a final determination is made, has surrendered such a license while formal disciplinary proceedings involving professional conduct are pending. By individual or entity we mean a medical or psychological consultant, consultative examination provider, or diagnostic test facility. Also see §§404.1519 and 404.1519g(b).

[56 FR 36954, Aug. 1, 1991]

§404.1504 Determinations by other organizations and agencies.

A decision by any nongovernmental agency or any other governmental agency about whether you are disabled or blind is based on its rules and is not our decision about whether you are disabled or blind. We must make a disability or blindness determination based on social security law. Therefore, a determination made by another agency that you are disabled or blind is not binding on us.

DEFINITION OF DISABILITY

§404.1505 Basic definition of disability.

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairmentich can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment, which makes you unable to do your previous work or any other substantial gainful activity which exists in the national economy. To determine whether you are able to do any other work, we consider your residual functional capacity and your age, education, and work experience. We will use this definition of disability if you

are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability before age 22 or, with respect to disability benefits payable for months after December 1990, as a widow, widower, or surviving divorced spouse.

(b) There are different rules for determining disability for individuals who are statutorily blind. We discuss these in §§ 404.1581 through 404.1587. There are also different rules for determining disability for widows, widowers, and surviving divorced spouses for monthly benefits for months prior to January 1991. We discuss these rules in §§ 404.1577, 404.1578, and 404.1579.

[45 FR 55584, Aug. 20, 1980, as amended at 51 FR 10616, Mar. 28, 1986; 57 FR 30120, July 8, 1992]

§ 404.1506 When we will not consider your impairment.

(a) *Permanent exclusion of felony-related impairment.* In determining whether you are under a disability, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your commission of a felony after October 19, 1980, if you are subsequently convicted of this crime.Your subsequent conviction will invalidate any prior determination establishing disability if that determination was based upon any impairment, or aggravation, which we must exclude under this rule.

(b) *Limited use of impairment arising in prison.* In determining whether you are under a disability for purposes of benefit payments, we will not consider any physical or mental impairment, or any increase in severity (aggravation) of a preexisting impairment, which arises in connection with your confinement in a jail, prison, or other penal institution or correctional facility for conviction of a felony committed after October 19, 1980. The exclusion of the impairment, or aggravation, applies in determining disability for benefits payable for any month during which you are confined. This rule does not preclude the establishment of a period of disability based upon the impairment or aggravation. You may become entitled to benefits upon release from prison provided that you apply and are under a disability at the time.

(c) *Felonious offenses.* We will consider an offense a felony if—

(1) It is a felony under applicable law; or

(2) In a jurisdiction which does not classify any crime as a felony, it is an offense punishable by death or imprisonment for a term exceeding one year.

(d) *Confinement.* In general, a jail, prison, or other penal institution or correctional facility is a facility which is under the control and jurisdiction of the agency in charge of the penal system or in which convicted criminals can be incarcerated. Confinement in such a facility continues as long as you are under a sentence of confinement and have not been released due to parole or pardon. You are considered confined even though you are temporarily or intermittently outside of the facility (e.g., on work release, attending school, or hospitalized).

[48 FR 5714, Feb. 8, 1983]

§ 404.1508 What is needed to show an impairment.

If you are not doing substantial gainful activity, we always look first at your physical or mental impairment(s) to determine whether you are disabled or blind. Your impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms (see § 404.1527). (See § 404.1528 for further information about what we mean by symptoms, signs, and laboratory findings.)

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 36954, Aug. 1, 1991]

§ 404.1509 How long the impairment must last.

Unless your impairment is expected to result in death, it must have lasted or must be expected to last for a continuous period of at least 12 months. We call this the duration requirement.

§404.1510 Meaning of substantial gainful activity.

Substantial gainful activity means work that—

(a) Involves doing significant and productive physical or mental duties; and

(b) Is done (or intended) for pay or profit.

(See §404.1572 for further details about what we mean by substantial gainful activity.)

§404.1511 Definition of a disabling impairment.

(a) *Disabled workers, persons disabled since childhood and, for months after December 1990, disabled widows, widowers, and surviving divorced spouses.* If you are entitled to disability cash benefits as a disabled worker, or to child's insurance benefits, or, for monthly benefits payable after December 1990, to widow's, widower's, or surviving divorced spouse's monthly benefits, a disabling impairment is an impairment (or combination of impairments) which, of itself, is so severe that it meets or equals a set of criteria in the Listing of Impairments in appendix 1 of this subpart or which, when considered with your age, education, and work experience, would result in a finding that you are disabled under §404.1594. In determining whether you have a disabling impairment, earnings are not considered.

(b) *Disabled widows, widowers, and surviving divorced spouses, for monthly benefits for months prior to January 1991.* If you have been entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse and we must decide whether you had a disabling impairment for any time prior to January 1991, a disabling impairment is an impairment (or combination of impairments) which, of itself, was so severe that it met or equaled a set of criteria in the Listing of Impairments in appendix 1 of this subpart, or results in a finding that you were disabled under §404.1579. In determining whether you had a disabling impairment, earnings are not considered.

[57 FR 30120, July 8, 1992]

EVIDENCE

§404.1512 Evidence of your impairment.

(a) *General.* In general, you have to prove to us that you are blind or disabled. Therefore, you must bring to our attention everything that shows that you are blind or disabled. This means that you must furnish medical and other evidence that we can use to reach conclusions about your medical impairment(s) and, if material to the determination of whether you are blind or disabled, its effect on your ability to work on a sustained basis. We will consider only impairment(s) you say you have or about which we receive evidence.

(b) *What we mean by ''evidence.''* Evidence is anything you or anyone else submits to us or that we obtain that relates to your claim. This includes, but is not limited to:

(1) Objective medical evidence, that is, medical signs and laboratory findings as defined in §404.1528 (b) and (c);

(2) Other evidence from medical sources, such as medical history, opinions, and statements about treatment you have received;

(3) Statements you or others make about your impairment(s), your restrictions, your daily activities, your efforts to work, or any other relevant statements you make to medical sources during the course of examination or treatment, or to us during interviews, on applications, in letters, and in testimony in our administrative proceedings;

(4) Information from other sources, as described in §404.1513(e);

(5) Decisions by any governmental or nongovernmental agency about whether you are disabled or blind; and

(6) At the administrative law judge and Appeals Council levels, 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 experts we consult based on their review of the evidence in your case record. See §§404.1527(f)(2) and (f)(3).

(c) *Your responsibility.* You must provide medical evidence showing that

you have an impairment(s) and how severe it is during the time you say that you are disabled. If we ask you, you must also provide evidence about:

(1) Your age;

(2) Your education and training;

(3) Your work experience;

(4) Your daily activities both before and after the date you say that you became disabled;

(5) Your efforts to work; and

(6) Any other factors showing how your impairment(s) affects your ability to work. In §§ 404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors.

(d) *Our responsibility*. Before we make a determination that you are not disabled, we will develop your complete medical history for at least the 12 months preceding the month in which you file your application unless there is a reason to believe that development of an earlier period is necessary or unless you say that your disability began less than 12 months before you filed your application. We will make every reasonable effort to help you get medical reports from your own medical sources when you give us permission to request the reports.

(1) ''Every reasonable effort'' means that we will make an initial request for evidence from your medical source and, at any time between 10 and 20 calendar days after the initial request, if the evidence has not been received, we will make one followup request to obtain the medical evidence necessary to make a determination. The medical source will have a minimum of 10 calendar days from the date of our followup request to reply, unless our experience with that source indicates that a longer period is advisable in a particular case.

(2) By ''complete medical history,'' we mean the records of your medical source(s) covering at least the 12 months preceding the month in which you file your application. If you say that your disability began less than 12 months before you filed your application, we will develop your complete medical history beginning with the month you say your disability began unless we have reason to believe your disability began earlier. If applicable, we will develop your complete medical history for the 12-month period prior to (1) the month you were last insured for disability insurance benefits (see § 404.130), (2) the month ending the 7-year period you may have to establish your disability and you are applying for widow's or widower's benefits based on disability (see § 404.335(c)(1)), or (3) the month you attain age 22 and you are applying for child's benefits based on disability (see § 404.350(e)).

(e) *Recontacting medical sources*. When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.

(1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques. We may do this by requesting copies of your medical source's records, a new report, or a more detailed report from your medical source, including your treating source, or by telephoning your medical source. In every instance where medical evidence is obtained over the telephone, the telephone report will be sent to the source for review, signature and return.

(2) We may not seek additional evidence or clarification from a medical source when we know from past experience that the source either cannot or will not provide the necessary findings.

(f) *Need for consultative examination*. If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See §§ 404.1517 through 404.1519t for the rules governing the

consultative examination process. Generally, we will not request a consultative examination until we have made every reasonable effort to obtain evidence from your own medical sources. However, in some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. We will not evaluate this evidence until we have made every reasonable effort to obtain evidence from your medical sources.

[56 FR 36954, Aug. 1, 1991, as amended at 65 FR 11875, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11875, Mar. 7, 2000, §404.1512 was amended by revising paragraph (b)(6), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1512 Evidence of your impairment.

* * * * *

(b) * * *

(6) At the administrative law judge and Appeals Council levels, certain findings, other than the ultimate determination about whether you are disabled, made by State agency medical or psychological consultants and other program physicians or psychologists, and opinions expressed by medical advisors based on their review of the evidence in your case record. See §404.1527(f) (2) and (3).

* * * * *

§404.1513 Medical evidence of your impairment.

(a) *Acceptable sources.* We need reports about your impairments from acceptable medical sources. Acceptable medical sources are—

(1) Licensed physicians;

(2) Licensed osteopaths;

(3) Licensed or certified psychologists;

(4) Licensed optometrists for the measurement of visual acuity and visual fields (we may need a report from a physician to determine other aspects of eye diseases); and

(5) Persons authorized to send us a copy or summary of the medical records of a hospital, clinic, sanitorium, medical institution, or health care facility. Generally, the copy or summary should be certified as accurate by the custodian or by any authorized employee of the Social Security Administration, Veterans' Administration, or State agency. However, we will not return an uncertified copy or summary for certification unless there is some question about the document.

(b) *Medical reports.* Medical reports should include—

(1) Medical history;

(2) Clinical findings (such as the results of physical or mental status examinations);

(3) Laboratory findings (such as blood pressure, x-rays);

(4) Diagnosis (statement of disease or injury based on its signs and symptoms);

(5) Treatment prescribed with response, and prognosis; and

(6) A statement about what you can still do despite your impairment(s) based on the acceptable medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section (except in statutory blindness claims). Although we will request a medical source statement about what you can still do despite your impairment(s), the lack of the medical source statement will not make the report incomplete. See §404.1527.

(c) *Statements about what you can still do.* At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical and psychological consultants and other program physicians and psychologists to be ''statements about what you can still do'' made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do (based on the acceptable 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 as follows (See §§404.1527 and 404.1545(c)):

(1) The acceptable 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 acceptable medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

(d) *Completeness.* The medical evidence, including the clinical and laboratory findings, must be complete and detailed enough to allow us to make a determination about whether you are disabled or blind. It must allow us to determine—

(1) The nature and limiting effects of your impairment(s) for any period in question;

(2) The probable duration of your impairment; and

(3) Your residual functional capacity to do work-related physical and mental activities.

(e) *Information from other sources.* Information from other sources may also help us to understand how your impairment affects your ability to work. Other sources include—

(1) Public and private social welfare agencies;

(2) Observations by non-medical sources; and

(3) Other practitioners (for example, naturopaths, chiropractors, audiologists, etc.).

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 36955, Aug. 1, 1991; 65 FR 11875, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11875, Mar. 7, 2000, § 404.1513 was amended by revising the first sentence of paragraph (b)(6) and paragraph (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1513 Medical evidence of your impairment.

* * * * *

(b) * * *

(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). * * *

(c) *Statements about what you can still do.* Statements about what you can still do (based on the medical source's findings on the factors under paragraphs (b)(1) through (b)(5) of this section) should describe, but are not limited to, the kinds of physical and mental capabilities listed below. See §§ 404.1527 and 404.1545(c).

(1) The medical source's opinion about your ability, despite your impairment(s), to do work-related activities such as sitting, standing, walking, lifting, carrying, handling objects, hearing, speaking, and traveling; and

(2) In cases of mental impairment(s), the medical source's opinion about your ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and work pressures in a work setting.

* * * * *

§ 404.1514 When we will purchase existing evidence.

We need specific medical evidence to determine whether you are disabled or blind. You are responsible for providing that evidence. However, we will pay physicians not employed by the Federal government and other non-Federal providers of medical services for the reasonable cost of providing us with existing medical evidence that we need and ask for after November 30, 1980.

[46 FR 45757, Sept. 15, 1981]

§ 404.1515 Where and how to submit evidence.

You may give us evidence about your impairment at any of our offices or at the office of any State agency authorized to make disability determinations. You may also give evidence to one of our employees authorized to accept evidence at another place. For more information about this, see subpart H of this part.

§ 404.1516 If you fail to submit medical and other evidence.

If you do not give us the medical and other evidence that we need and request, we will have to make a decision based on information available in your case. We will not excuse you from giving us evidence because you have religious or personal reasons against medical examinations, tests, or treatment.

§404.1517 Consultative examination at our expense.

If your medical sources cannot or will not give us sufficient medical evidence about your impairment for us to determine whether you are disabled or blind, we may ask you to have one or more physical or mental examinations or tests. We will pay for these examinations. However, we will not pay for any medical examination arranged by you or your representative without our advance approval. If we arrange for the examination or test, we will give you reasonable notice of the date, time, and place the examination or test will be given, and the name of the person or facility who will do it. We will also give the examiner any necessary background information about your condition.

[56 FR 36956, Aug. 1, 1991]

§404.1518 If you do not appear at a consultative examination.

(a) *General.* If you are applying for benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arrange for you to get information we need to determine your disability or blindness, we may find that you are not disabled or blind. If you are already receiving benefits and do not have a good reason for failing or refusing to take part in a consultative examination or test which we arranged for you, we may determine that your disability or blindness has stopped because of your failure or refusal. Therefore, if you have any reason why you cannot go for the scheduled appointment, you should tell us about this as soon as possible before the examination date. If you have a good reason, we will schedule another examination. We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have a good reason for failing to attend a consultative examination.

(b) *Examples of good reasons for failure to appear.* Some examples of what we consider good reasons for not going to a scheduled examination include—

(1) Illness on the date of the scheduled examination or test;

(2) Not receiving timely notice of the scheduled examination or test, or receiving no notice at all;

(3) Being furnished incorrect or incomplete information, or being given incorrect information about the physician involved or the time or place of the examination or test, or;

(4) Having had death or serious illness occur in your immediate family.

(c) *Objections by your physician.* If any of your treating physicians tell you that you should not take the examination or test, you should tell us at once. In many cases, we may be able to get the information we need in another way. Your physician may agree to another type of examination for the same purpose.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994]

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

§404.1519 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating source or another medical source, including a pediatrician when appropriate. The decision to purchase a consultative examination will be made on an individual case basis in accordance with the provisions of §§404.1519a through 404.1519f. Selection of the source for the examination will be consistent with the provisions of §404.1503a and §§404.1519g through 404.1519j. The rules and procedures for requesting consultative examinations set forth in §§404.1519a and 404.1519b are applicable at the reconsideration and hearing levels of review, as well as the initial level of determination.

[56 FR 36956, Aug. 1, 1991, as amended at 65 FR 11875, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11875, Mar. 7, 2000, §404.1519 was amended by revising the first sentence, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1519 The consultative examination.

A consultative examination is a physical or mental examination or test purchased for you at our request and expense from a treating physician or psychologist, another source of record, or an independent source, including a pediatrician when appropriate. * * *

§ 404.1519a When we will purchase a consultative examination and how we will use it.

(a)(1) *General.* The decision to purchase a consultative examination for you will be made after we have given full consideration to whether the additional information needed (e.g., clinical findings, laboratory tests, diagnosis, and prognosis) is readily available from the records of your medical sources. See § 404.1512 for the procedures we will follow to obtain evidence from your medical sources. Before purchasing a consultative examination, we will consider not only existing medical reports, but also the disability interview form containing your allegations as well as other pertinent evidence in your file.

(2) When we purchase a consultative examination, we will use the report from the consultative examination to try to resolve a conflict or ambiguity if one exists. We will also use a consultative examination to secure needed medical evidence the file does not contain such as clinical findings, laboratory tests, a diagnosis or prognosis necessary for decision.

(b) *Situations requiring a consultative examination.* A consultative examination may be purchased when the evidence as a whole, both medical and nonmedical, is not sufficient to support a decision on your claim. Other situations, including but not limited to the situations listed below, will normally require a consultative examination:

(1) The additional evidence needed is not contained in the records of your medical sources;

(2) The evidence that may have been available from your treating or other medical sources cannot be obtained for reasons beyond your control, such as death or noncooperation of a medical source;

(3) Highly technical or specialized medical evidence that we need is not available from your treating or other medical sources;

(4) A conflict, inconsistency, ambiguity or insufficiency in the evidence must be resolved, and we are unable to do so by recontacting your medical source; or

(5) There is an indication of a change in your condition that is likely to affect your ability to work, but the current severity of your impairment is not established.

[56 FR 36956, Aug. 1, 1991]

§ 404.1519b When we will not purchase a consultative examination.

We will not purchase a consultative examination in situations including, but not limited to, the following situations:

(a) In period of disability and disability insurance benefit claims, when you do not meet the insured status requirement in the calendar quarter you allege you became disabled or later and there is no possibility of establishing an earlier onset;

(b) In claims for widow's or widower's benefits based on disability, when your alleged month of disability is after the end of the 7-year period specified in § 404.335(c)(1) and there is no possibility of establishing an earlier onset date, or when the 7-year period expired in the past and there is no possibility of establishing an onset date prior to the date the 7-year period expired;

(c) In disability insurance benefit claims, when your insured status expired in the past and there is no possibility of establishing an onset date prior to the date your insured status expired;

(d) When any issues about your actual performance of substantial gainful activity or gainful activity have not been resolved;

(e) In claims for child's benefits based on disability, when it is determined that your alleged disability did not begin before the month you attained age 22, and there is no possibility of establishing an onset date earlier than the month in which you attained age 22;

(f) In claims for child's benefits based on disability that are filed concurrently with the insured individual's

claim and entitlement cannot be established for the insured individual;

(g) In claims for child's benefits based on disability where entitlement is precluded based on other nondisability factors.

[56 FR 36956, Aug. 1, 1991]

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

§404.1519f Type of purchased examinations.

We will purchase only the specific examinations and tests we need to make a determination in your claim. For example, we will not authorize a comprehensive medical examination when the only evidence we need is a special test, such as an X-ray, blood studies, or an electrocardiogram.

[56 FR 36956, Aug. 1, 1991]

§404.1519g Who we will select to perform a consultative examination.

(a) We will purchase a consultative examination only from a qualified medical source. The medical source may be your own physician or psychologist, or another source. If you are a child, the medical source we choose may be a pediatrician. For a more complete list of medical sources, see §404.1513.

(b) By ''qualified,'' we mean that the medical source must be currently licensed in the State and have the training and experience to perform the type of examination or test we will request; the medical source must not be barred from participation in our programs under the provisions of §404.1503a. The medical source must also have the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

(c) The medical source we choose may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse) must meet appropriate licensing or certification requirements of the State. See §404.1503a.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, §404.1519g was amended by revising the last sentence of paragraph (a) and the first sentence of paragraph (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519g Who we will select to perform a consultative examination.

(a) * * * For a more complete list of medical sources, see §404.1513(a).

* * * * *

(c) The physician or psychologist we choose may use support staff to help perform the consultative examination. * * *

§404.1519h Your treating source.

When in our judgment your treating source 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 source will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating source is ordinarily the preferred source.

[65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, §404.1519h was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519h Your treating physician or psychologist.

When in our judgment your treating physician or psychologist is qualified, equipped, and willing to perform the additional examination or tests for the fee schedule payment, and generally furnishes complete and timely reports, your treating physician or psychologist will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating physician or psychologist is ordinarily the preferred source.

[56 FR 36957, Aug. 1, 1991]

§404.1519i Other sources for consultative examinations.

We will use a medical source other than your treating source for a purchased examination or test in situations including, but not limited to, the following situations:

(a) Your treating source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your treating source;

(c) You prefer a source other than your treating source and have a good reason for your preference;

(d) We know from prior experience that your treating source may not be a productive source, *e.g.*, he or she has consistently failed to provide complete or timely reports.

[65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, § 404.1519i was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1519i Other sources for consultative examinations.

We will use a source other than your treating physician or psychologist for a purchased examination or test in situations including, but not limited to, the following situations:

(a) Your treating physician or psychologist prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your treating physician or psychologist;

(c) You prefer a source other than your treating physician or psychologist and have a good reason for your preference;

(d) We know from prior experience that your treating physician or psychologist may not be a productive source, e.g., he or she has consistently failed to provide complete or timely reports.

[56 FR 36957, Aug. 1, 1991]

§ 404.1519j Objections to the medical source designated to perform the consultative examination.

You or your representative may object to your being examined by a medical source we have designated to perform a consultative examination. If there is a good reason for the objection, we will schedule the examination with another medical source. A good reason may be that the medical source we designated had previously represented an interest adverse to you. For example, the medical source 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 medical source's office location (*e.g.*, 2nd floor, no elevator), travel restrictions, and whether the medical source had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is that a medical source allegedly ''lacks objectivity'' in general, but not in relation to you personally, we will review the allegations. See § 404.1519s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another medical source while a review is being conducted. We will handle any objection to use of the substitute medical source in the same manner. However, if we had previously conducted such a review and found that the reports of the medical source in question conformed to our guidelines, we will not change your examination.

[65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, § 404.1519j was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1519j Objections to the designated physician or psychologist.

You or your representative may object to your being examined by a designated physician or psychologist. If there is a good reason for the objection, we will schedule the examination with another physician or psychologist. A good reason may be that the consultative examination physician or psychologist had previously represented an interest adverse to you. For example, the physician or psychologist may have represented your employer in a workers' compensation case or may have been involved in an insurance claim or legal action adverse to you. Other things we will consider include: the presence of a language barrier, the physician's or psychologist's office location (e.g., 2nd floor, no elevator), travel restrictions, and whether the physician or psychologist had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is because a physician or psychologist allegedly ''lacks objectivity'' in general, but not in relation to you personally, we will review the allegations. See § 404.1519s. To avoid a delay in processing your claim, the consultative examination in your case will be changed to another physician or psychologist while a review is being conducted. We will handle any objection to use of the substitute physician or psychologist in the same

manner. However, if we had previously conducted such a review and found that the reports of the consultative physician or psychologist in question conformed to our guidelines, we will not change your examination.

[56 FR 36957, Aug. 1, 1991]

§404.1519k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized tests, such as pulmonary function studies, electrocardiograms, and stress tests) from a medical source.

(a) The rate of payment to be used for purchasing medical or other services necessary to make determinations of disability may not exceed the highest rate paid by Federal or public agencies in the State for the same or similar types of service. See §§404.1624 and 404.1626.

(b) If a physician's bill or a request for payment for a physician's services includes a charge for a laboratory test for which payment may be made under this part, the amount payable with respect to the test shall be determined as follows:

(1) If the bill or request for payment indicates that the test was personally performed or supervised by the physician who submitted the bill (or for whose services the request for payment was made) or by another physician with whom that physician shares his or her practice, the payment will be based on the physician's usual and customary charge for the test or the rates of payment which the State uses for purchasing such services, whichever is the lesser amount.

(2) If the bill or request for payment indicates that the test was performed by an independent laboratory, the amount of reimbursement will not exceed the billed cost of the independent laboratory or the rate of payment which the State uses for purchasing such services, whichever is the lesser amount. A nominal payment may be made to the physician for collecting, handling and shipping a specimen to the laboratory if the physician bills for such a service. The total reimbursement may not exceed the rate of payment which the State uses for purchasing such services.

(c) The State will assure that it can support the rate of payment it uses. The State shall also be responsible for monitoring and overseeing the rate of payment it uses to ensure compliance with paragraphs (a) and (b) of this section.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, §404.1519k was amended by revising the introductory text, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519k Purchase of medical examinations, laboratory tests, and other services.

We may purchase medical examinations, including psychiatric and psychological examinations, X-rays and laboratory tests (including specialized tests such as pulmonary function studies, electrocardiograms, stress tests, etc.) from a licensed physician or psychologist, hospital or clinic.

* * * * *

§404.1519m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating source or other medical source and will use the results to help us evaluate impairment severity or prognosis. However, we will not order diagnostic tests or procedures that involve significant risk to you, such as myelograms, arteriograms, or cardiac catheterizations for the evaluation of disability under the Social Security program. Also, a State agency medical consultant must approve the ordering of any diagnostic test or procedure when there is a chance it may involve significant risk. The responsibility for deciding whether to perform the examination rests with the medical source designated to perform the consultative examination.

[56 FR 36957, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, §404.1519m was amended by revising the first and last sentences, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1519m Diagnostic tests or procedures.

We will request the results of any diagnostic tests or procedures that have been performed as part of a workup by your treating physician or psychologist or other medical source and will use the results to help us evaluate impairment severity or prognosis. * * * The responsibility for deciding whether to perform the examination rests with the consultative examining physician or psychologist.

§ 404.1519n Informing the medical source of examination scheduling, report content, and signature requirements.

The medical sources 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 medical sources who perform consultative examinations at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) *Scheduling.* In scheduling full consultative examinations, sufficient time should be allowed to permit the medical source to take a case history and perform the examination, including any needed tests. The following minimum scheduling intervals (i.e., time set aside for the individual, not the actual duration of the consultative examination) should be used.

(1) Comprehensive general medical examination—at least 30 minutes;

(2) Comprehensive musculoskeletal or neurological examination—at least 20 minutes;

(3) Comprehensive psychiatric examination—at least 40 minutes;

(4) Psychological examination—at least 60 minutes (Additional time may be required depending on types of psychological tests administered); and

(5) All others—at least 30 minutes, or in accordance with accepted medical practices.

We recognize that actual practice will dictate that some examinations may require longer scheduling intervals depending on the circumstances in a particular situation. We also recognize that these minimum intervals may have to be adjusted to allow for those claimants who do not attend their scheduled examination. The purpose of these minimum scheduling timeframes is to ensure that such examinations are complete and that sufficient time is made available to obtain the information needed to make an accurate determination in your case. State agencies will monitor the scheduling of examinations (through their normal consultative examination oversight activities) to ensure that any overscheduling is avoided, as overscheduling may lead to examinations that are not thorough.

(b) *Report content.* The reported results of your medical history, examination, requested laboratory findings, discussions and conclusions must conform to accepted professional standards and practices in the medical field for a complete and competent examination. The facts in a particular case and the information and findings already reported in the medical and other evidence of record will dictate the extent of detail needed in the consultative examination report for that case. Thus, the detail and format for reporting the results of a purchased examination will vary depending upon the type of examination or testing requested. The reporting of information will differ from one type of examination to another when the requested examination relates to the performance of tests such as ventilatory function tests, treadmill exercise tests, or audiological tests. The medical report must be complete enough to help us determine the nature, severity, and duration of the impairment, and residual functional capacity. The report should reflect your statement of your symptoms, not simply the medical source's statements or conclusions. The medical source's report of the consultative examination should include the objective medical facts as well as observations and opinions.

(c) *Elements of a complete consultative examination.* A complete consultative examination is one which involves all the elements of a standard examination in the applicable medical specialty. When the report of a complete consultative examination is involved, the report should include the following elements:

(1) Your major or chief complaint(s);

(2) A detailed description, within the area of specialty of the examination, of the history of your major complaint(s);

(3) A description, and disposition, of pertinent ''positive'' and ''negative'' detailed findings based on the history, examination and laboratory tests related to the major complaint(s), and any other abnormalities or lack thereof reported or found during examination or laboratory testing;

(4) The results of laboratory and other tests (e.g., X-rays) performed according to the requirements stated in the Listing of Impairments (see appendix 1 of this subpart P);

(5) The diagnosis and prognosis for your impairment(s);

(6) A statement about what you can still do despite your impairment(s), unless the claim is based on statutory blindness. This statement should describe the opinion of the medical source 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 medical source 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. Although we will ordinarily request, as part of the consultative examination process, a medical source statement about what you can still do despite your impairment(s), the absence of such a statement in a consultative examination report will not make the report incomplete. See §404.1527; and

(7) In addition, the medical source 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 medical source 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 medical source who actually performed the examination. This attests to the fact that the medical source 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 medical source on a report annotated ''not proofed'' or ''dictated but not read'' is not acceptable. A rubber stamp signature of a medical source or the medical source's signature entered by any other person is not acceptable.

[56 FR 36958, Aug. 1, 1991, as amended at 65 FR 11876, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11876, Mar. 7, 2000, §404.1519n was amended by revising the section heading and the first and last sentences of the introductory text, adding a heading to paragraph (a) and revising the first sentence of paragraph (a) introductory text, revising the last two sentences of paragraph (b), revising the second sentence of and adding two sentences at the end of paragraph (c)(6), and by revising paragraphs (c)(7) and (e), effective Mar. 7, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.

The physicians or psychologists who perform consultative examinations will have a good understanding of our disability programs and their evidentiary requirements. * * * 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. * * *

(b) * * * 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) * * *

(6) * * * 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.

* * * * *

(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.

§ 404.1519o When a properly signed consultative examination report has not been received.

If a consultative examination report is received unsigned or improperly signed we will take the following action.

(a) *When we will make determinations and decisions without a properly signed report.* We will make a determination or decision in the circumstances specified in paragraphs (a)(1) and (a)(2) of this section without waiting for a properly signed consultative examination report. After we have made the determination or decision, we will obtain a properly signed report and include it in the file unless the medical source 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 medical source who performed the original examination cannot be obtained because the medical source is out of the country for an extended period of time, or on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another medical source:

(1) Denial; or

(2) Cessation; or

(3) Allowance of a period of disability which has ended; or

(4) Allowance with an onset date later than alleged.

[56 FR 36958, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11877, Mar. 7, 2000, § 404.1519o was amended by revising the last sentence of paragraph (a) introductory text and the last sentence of paragraph (b) introductory text, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 404.1519o When a properly signed consultative examination report has not been received.

* * * * *

(a) * * * 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.

* * * * *

(b) * * * 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.

* * * * *

§404.1519p Reviewing reports of consultative examinations.

(a) We will review the report of the consultative examination to determine whether the specific information requested has been furnished. We will consider the following factors in reviewing the report:

(1) Whether the report provides evidence which serves as an adequate basis for decisionmaking in terms of the impairment it assesses;

(2) Whether the report is internally consistent; Whether all the diseases, impairments and complaints described in the history are adequately assessed and reported in the clinical findings; Whether the conclusions correlate the findings from your medical history, clinical examination and laboratory tests and explain all abnormalities;

(3) Whether the report is consistent with the other information available to us within the specialty of the examination requested; Whether the report fails to mention an important or relevant complaint within that specialty that is noted in other evidence in the file (e.g., your blindness in one eye, amputations, pain, alcoholism, depression);

(4) Whether this is an adequate report of examination as compared to standards set out in the course of a medical education; and

(5) Whether the report is properly signed.

(b) If the report is inadequate or incomplete, we will contact the medical source who performed the consultative examination, give an explanation of our evidentiary needs, and ask that the medical source furnish the missing information or prepare a revised report.

(c) With your permission, or when the examination discloses new diagnostic information or test results that reveal a potentially life-threatening situation, we will refer the consultative examination report to your treating source. When we refer the consultative examination report to your treating source without your permission, we will notify you that we have done so.

(d) We will perform ongoing special management studies on the quality of consultative examinations purchased from major medical sources and the appropriateness of the examinations authorized.

(e) We will take steps to ensure that consultative examinations are scheduled only with medical sources who have access to the equipment required to provide an adequate assessment and record of the existence and level of severity of your alleged impairments.

[56 FR 36959, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11877, Mar. 7, 2000, §404.1519p was amended by revising paragraphs (b) and (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519p Reviewing reports of consultative examinations.

* * * * *

(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.

* * * * *

§404.1519q Conflict of interest.

All implications of possible conflict of interest between medical or psychological consultants and their medical or psychological practices will be avoided. Such consultants are not only those physicians and psychologists who work for us directly but are also those who do review and adjudication work in the State agencies. Physicians and

psychologists who work for us directly as employees or under contract will not work concurrently for a State agency. Physicians and psychologists who do review work for us will not perform consultative examinations for us without our prior approval. In such situations, the physician or psychologist will disassociate himself or herself from further involvement in the case and will not participate in the evaluation, decision, or appeal actions. In addition, neither they, nor any member of their families, will acquire or maintain, either directly or indirectly, any financial interest in a medical partnership, corporation, or similar relationship in which consultative examinations are provided. Sometimes physicians and psychologists who do review work for us will have prior knowledge of a case; for example, when the claimant was a patient. Where this is so, the physician or psychologist will not participate in the review or determination of the case. This does not preclude the physician or psychologist from submitting medical evidence based on treatment or examination of the claimant.

[56 FR 36959, Aug. 1, 1991]

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

§ 404.1519s Authorizing and monitoring the consultative examination.

(a) Day-to-day responsibility for the consultative examination process rests with the State agencies that make disability determinations for us.

(b) The State agency will maintain a good working relationship with the medical community in order to recruit sufficient numbers of physicians and other providers of medical services to ensure ready availability of consultative examination providers.

(c) Consistent with Federal and State laws, the State agency administrator will work to achieve appropriate rates of payment for purchased medical services.

(d) Each State agency will be responsible for comprehensive oversight management of its consultative examination program, with special emphasis on key providers.

(e) A key consultative examination provider is a provider that meets at least one of the following conditions:

(1) Any consultative examination provider with an estimated annual billing to the Social Security disability programs of at least $100,000; or

(2) Any consultative examination provider with a practice 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 medical sources. This includes physician approval for the ordering of any diagnostic test or procedure where the question of significant risk to the claimant/beneficiary might be raised. See § 404.1519m.

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

(8) Procedures to encourage active participation by physicians in the consultative examination oversight program;

(9) Procedures for handling complaints;

(10) Procedures for evaluating claimant reactions to key providers; and

(11) A program of systematic, onsite reviews of key providers that will include annual onsite reviews of such providers when claimants are present for examinations. This provision does not contemplate that such reviews will involve participation in the actual examinations but, rather, offer an opportunity to talk with claimants at the provider's site before and after the examination and to review the provider's overall operation.

(g) The State agencies will cooperate with us when we conduct monitoring activities in connection with their oversight management of their consultative examination programs.

[56 FR 36959, Aug. 1, 1991, as amended at 65 FR 11877, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11877, Mar. 7, 2000, §404.1519s was amended by revising paragraph (e)(2) and the first sentence of paragraph (f)(6), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1519s Authorizing and monitoring the consultative examination.

* * * * *

(e) * * *

(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

* * * * *

(f) * * *

(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. * * *

* * * * *

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

§404.1519t Consultative examination oversight.

(a) We will ensure that referrals for consultative examinations and purchases of consultative examinations are made in accordance with our policies. We will also monitor both the referral processes and the product of the consultative examinations obtained. This monitoring may include reviews by independent medical specialists under direct contract with SSA.

(b) Through our regional offices, we will undertake periodic comprehensive reviews of each State agency to evaluate each State's management of the consultative examination process. The review will involve visits to key providers, with State staff participating, including a program physician when the visit will deal with medical techniques or judgment, or factors that go to the core of medical professionalism.

(c) We will also perform ongoing special management studies of the quality of consultative examinations purchased from key providers and other sources and the appropriateness of the examinations authorized.

[56 FR 36960, Aug. 1, 1991]

EVALUATION OF DISABILITY

§404.1520 Evaluation of disability in general.

(a) *Steps in evaluating disability.* We consider all evidence in your case record when we make a determination or decision whether you are disabled. When you file a claim for a period of disability and/or disability insurance benefits or for child's benefits based on disability, we use the following evaluation process. If you are doing substantial gainful activity, we will determine that you are not disabled. If you are not doing substantial gainful activity, we will first consider the effect of your physical or mental impairment; if you have more than one impairment, we will also consider the combined effect of your impairments. Your impairment(s) must be severe and meet the duration requirement before we can

find you to be disabled. We follow a set order to determine whether you are disabled. We review any current work activity, the severity of your impairment(s), your residual functional capacity, your past work, and your age, education, and work experience. If we can find that you are disabled or not disabled at any point in the review, we do not review your claim further. Once you have been found entitled to disability benefits, we follow a somewhat different order of evaluation to determine whether your entitlement continues, as explained in § 404.1594(f)(6).

(b) *If you are working.* If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.

(c) *You must have a severe impairment.* If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.

(d) *When your impairment(s) meets or equals a listed impairment in appendix 1.* If you have an impairment(s) which meets the duration requirement and is listed in appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.

(e) *Your impairments(s) must prevent you from doing past relevant work.* If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

(f) *Your impairment(s) must prevent you from doing any other work.* (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled.

(2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule (see § 404.1562).

[50 FR 8727, Mar. 5, 1985; 50 FR 19164, May 7, 1985, as amended at 56 FR 36960, Aug. 1, 1991]

§ 404.1520a Evaluation of mental impairments.

(a) *General.* The steps outlined in § 404.1520 apply to the evaluation of physical and mental impairments. In addition, in evaluating the severity of mental impairments for adults (persons age 18 and over) and in persons under age 18 when part A of the Listing of Impairments is used, a special procedure must be followed by us at each level of adminstrative review. Following this procedure will assist us in:

(1) Identifying additional evidence necessary for the determination of impairment severity;

(2) Considering and evaluating aspects of the mental disorder(s) relevant to your ability to work; and

(3) Organizing and presenting the findings in a clear, concise, and consistent manner.

(b) *Use of the procedure to record pertinent findings and rate the degree of functional loss.* (1) This procedure requires us to record the pertinent signs, symptoms, findings, functional limitations, and effects of treatment contained in your case record. This will assist us in determining if a mental impairment(s) exists. Whether or not a mental impairment(s) exists is decided in the same way the question of a physical impairment is decided, i.e., the evidence must be carefully reviewed and conclusions supported by it. The mental status examination and psychiatric history will ordinarily provide the needed information. (See § 404.1508 for further information about what is needed to show an impairment.)

(2) If we determine that a mental impairment(s) exists, this procedure then requires us to indicate whether certain medical findings which have been found especially relevant to the ability to work are present or absent.

(3) The procedure then requires us to rate the degree of functional loss resulting from the impairment(s). Four areas of function considered by us as essential to work have been identified, and the degree of functional loss in those areas must be rated on a scale that ranges from no limitation to a level of severity which is incompatible with the ability to perform those work-related functions. For the first two areas (activities of daily living and social functioning), the rating of limitation must be done based upon the following five point scale: none, slight, moderate, marked, and extreme. For the third area (concentration, persistence, or pace) the following five point scale must be used: never, seldom, often, frequent, and constant. For the fourth area (deterioration or decompensation in work or work-like settings), the following four point scale must be used: never, once or twice, repeated (three or more), and continual. The last two points for each of these scales represent a degree of limitation which is incompatible with the ability to perform the work-related function.

(c) *Use of the procedure to evaluate mental impairments.* Following the rating of the degree of functional loss resulting from the impairment, we must then determine the severity of the mental impairment(s).

(1) If the four areas considered by us as essential to work have been rated to indicate a degree of limitation as *none* or *slight* in the first and second areas, *never* or *seldom* in the third area, and *never* in the fourth area, we can generally conclude that the impairment is not severe, unless the evidence otherwise indicates there is significant limitation of your mental ability to do basic work activities (see §404.1521).

(2) If your mental impairment(s) is severe, we must then determine if it meets or equals a listed mental disorder. This is done by comparing our prior conclusions based on this procedure (i.e., the presence of certain medical findings considered by us as especially relevant to your ability to work and our rating of functional loss resulting from the mental impairment(s)) against the paragraph A and B criteria of the appropriate listed mental disorder(s). If we determine that paragraph C criteria will be used in lieu of paragraph B criteria (see listings 12.03 and 12.06), we will, by following this procedure, indicate on the document whether the evidence is sufficient to establish the presence or absence of the criteria. (See paragraph (d) of this section).

(3) If you have a severe impairment(s), but the impairment(s) neither meets nor equals the listings, we must then do a residual functional capacity assessment.

(4) At all adjudicative levels we must, in each case, incorporate the pertinent findings and conclusions based on this procedure in our decision rationale. Our rationale must show the significant history, including examination, laboratory findings, and functional limitations that we considered in reaching conclusions about the severity of the mental impairment(s).

(d) *Preparation of the document.* A standard document outlining the steps of this procedure must be completed by us in each case at the initial, reconsideration, administrative law judge hearing, and Appeals Council levels (when the Appeals Council issues a decision).

(1) At the initial and reconsideration levels the standard document must be completed and signed by our medical consultant. At the administrative law judge hearing level, several options are available:

(i) The administrative law judge may complete the document without the assistance of a medical advisor;

(ii) The administrative law judge may call a medical advisor for assistance in preparing the document; or

(iii) Where new evidence is received that is not merely cumulative of evidence already in your case file or where the issue of a mental impairment arises for the first time at the administrative law judge hearing level, the administrative law judge may decide to remand the case to the State agency for completion of the document and a new determination. Remand may also be made in situations where the services of a medical advisor are determined necessary but unavailable to the administrative law judge. In such circumstances, however, a remand may ordinarily be made only once.

(2) For all cases involving mental disorders at the administrative law judge hearing or Appeals Council levels, the standard document will be appended to the decision.

(Approved by the Office of Management and Budget under control number 0960–0413)

[50 FR 35065, Aug. 28, 1985, as amended at 55 FR 51229, Dec. 12, 1990; 57 FR 30120, July 8, 1992]

§ 404.1521 What we mean by an impairment(s) that is not severe.

(a) *Non-severe impairment(s).* An impairment or combination of impairments is not severe if it does not significantly limit your physical or mental ability to do basic work activities.

(b) *Basic work activities.* When we talk about basic work activities, we mean the abilities and aptitudes necessary to do most jobs. Examples of these include—

(1) Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

(2) Capacities for seeing, hearing, and speaking;

(3) Understanding, carrying out, and remembering simple instructions;

(4) Use of judgment;

(5) Responding appropriately to supervision, co-workers and usual work situations; and

(6) Dealing with changes in a routine work setting.

[50 FR 8728, Mar. 5, 1985]

§ 404.1522 When you have two or more unrelated impairments—initial claims.

(a) *Unrelated severe impairments.* We cannot combine two or more unrelated severe impairments to meet the 12-month duration test. If you have a severe impairment(s) and then develop another unrelated severe impairment(s) but neither one is expected to last for 12 months, we cannot find you disabled, even though the two impairments in combination last for 12 months.

(b) *Concurrent impairments.* If you have two or more concurrent impairments which, when considered in combination, are severe, we must also determine whether the combined effect of your impairments can be expected to continue to be severe for 12 months. If one or more of your impairments improves or is expected to improve within 12 months, so that the combined effect of your remaining impairments is no longer severe, we will find that you do not meet the 12-month duration test.

[50 FR 8728, Mar. 5, 1985]

§ 404.1523 Multiple impairments.

In determining whether your physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility under the law, we will consider the combined effect of all of your impairments without regard to whether any such impairment, if considered separately, would be of sufficient severity. If we do find a medically severe combination of impairments, the combined impact of the impairments will be considered throughout the disability determination process. If we do not find that you have a medically severe combination of impairments, we will determine that you are not disabled (see § 404.1520).

[50 FR 8728, Mar. 5, 1985]

MEDICAL CONSIDERATIONS

§ 404.1525 Listing of Impairments in appendix 1.

(a) *Purpose of the Listing of Impairments.* The Listing of Impairments describes, for each of the major body systems, impairments which are considered severe enough to prevent a person from doing any gainful activity. Most of the listed impairments are permanent or expected to result in death, or a specific statement of duration is made. For all others, the evidence must show that the impairment has lasted or is expected to last for a continuous period of at least 12 months.

(b) *Adult and childhood diseases.* The Listing of Impairments consists of two parts:

(1) *Part A* contains medical criteria that apply to adult persons age 18 and over. The medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons.

(2) *Part B* contains additional medical criteria that apply only to the evaluation of impairments of persons under age 18. Certain criteria in part A do not give appropriate consideration to the particular effects of the disease processes in childhood; i.e., when the disease process is generally found only in children or when the disease process differs in its effect on children than on adults. Additional criteria are included in part B, and the impairment categories are, to the extent possible, numbered to maintain a relationship with their counterparts in part A. In evaluating disability for a person under age 18, part B will be used first. If the medical criteria in part B do not apply, then the medical criteria in part A will be used.

(c) *How to use the Listing of Impairments.* Each section of the Listing of Impairments has a general introduction containing definitions of key concepts used in that section. Certain specific medical findings, some of which are required in establishing a diagnosis or in confirming the existence of an impairment for the purpose of this Listing, are also given in the narrative introduction. If the medical findings needed to support a diagnosis are not given in the introduction or elsewhere in the listing, the diagnosis must still be established on the basis of medically acceptable clinical and laboratory diagnostic techniques. Following the introduction in each section, the required level of severity of impairment is shown under ''Category of Impairments'' by one or more sets of medical findings. The medical findings consist of symptoms, signs, and laboratory findings.

(d) *Diagnosis of impairments.* We will not consider your impairment to be one listed in appendix 1 solely because it has the diagnosis of a listed impairment. It must also have the findings shown in the Listing of that impairment.

(e) *Addiction to alcohol or drugs.* If you have a condition diagnosed as addiction to alcohol or drugs, this will not, by itself, be a basis for determining whether you are, or are not, disabled. As with any other medical condition, we will decide whether you are disabled based on symptoms, signs, and laboratory findings.

(f) *Symptoms as criteria of listed impairment(s).* Some listed impairment(s) include symptoms usually associated with those impairment(s) as criteria. Generally, when a symptom is one of the criteria in a listed impairment, it is only necessary that the symptom be present in combination with the other criteria. It is not necessary, unless the listing specifically states otherwise, to provide information about the intensity, persistence or limiting effects of the symptom as long as all other findings required by the specific listing are present.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57941, Nov. 14, 1991]

§404.1526 Medical equivalence.

(a) *How medical equivalence is determined.* We will decide that your impairment(s) is medically equivalent to a listed impairment in appendix 1 if the medical findings are at least equal in severity and duration to the listed findings. We will compare the symptoms, signs, and laboratory findings about your impairment(s), as shown in the medical evidence we have about your claim, with the medical criteria shown with the listed impairment. If your impairment is not listed, we will consider the listed impairment most like your impairment to decide whether your impairment is medically equal. If you have more than one impairment, and none of them meets or equals a listed impairment, we will review the symptoms, signs, and laboratory findings about your impairments to determine whether the combination of your impairments is medically equal to any listed impairment.

(b) *Medical equivalence must be based on medical findings.* We will always base our decision about whether your impairment(s) is medically equal to a listed impairment on medical evidence only. Any medical findings in the evidence must be supported by medically acceptable clinical and laboratory diagnostic techniques. We will also consider the medical opinion given by one or more medical or psychological consultants designated by the Commissioner in deciding medical equivalence. (See §404.1616.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Commissioner includes any medical or psychological consultant employed or engaged to make medical judgments by the Social Security Administration, the Railroad Retirement Board, or a State agency authorized to make disability determinations. A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. (See § 404.1616 for the qualifications we consider necessary for a psychologist to be a consultant.)

[45 FR 55584, Aug. 20, 1980, as amended at 52 FR 33926, Sept. 9, 1987; 62 FR 38451, July 18, 1997]

§ 404.1527 Evaluating opinion evidence.

(a) *General.* (1) You can only be found disabled if you are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. See § 404.1505. Your impairment must result from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. See § 404.1508.

(2) Evidence that you submit or that we obtain may contain medical opinions. Medical opinions are statements from physicians and psychologists or other acceptable medical sources that reflect judgments about the nature and severity of your impairment(s), including your symptoms, diagnosis and prognosis, what you can still do despite impairment(s), and your physical or mental restrictions.

(b) *How we consider medical opinions.* In deciding whether you are disabled, we will always consider the medical opinions in your case record together with the rest of the relevant evidence we receive.

(c) *Making disability determinations.* After we review all of the evidence relevant to your claim, including medical opinions, we make findings about what the evidence shows.

(1) If all of the evidence we receive, including all medical opinion(s), is consistent, and there is sufficient evidence for us to decide whether you are disabled, we will make our determination or decision based on that evidence.

(2) If any of the evidence in your case record, including any medical opinion(s), is inconsistent with other evidence or is internally inconsistent, we will weigh all of the evidence and see whether we can decide whether you are disabled based on the evidence we have.

(3) If the evidence is consistent but we do not have sufficient evidence to decide whether you are disabled, or if after weighing the evidence we decide we cannot reach a conclusion about whether you are disabled, we will try to obtain additional evidence under the provisions of §§ 404.1512 and 404.1519 through 404.1519h. We will request additional existing records, recontact your treating sources or any other examining sources, ask you to undergo a consultative examination at our expense, or ask you or others for more information. We will consider any additional evidence we receive together with the evidence we already have.

(4) When there are inconsistencies in the evidence that cannot be resolved, or when despite efforts to obtain additional evidence the evidence is not complete, we will make a determination or decision based on the evidence we have.

(d) *How we weigh medical opinions.* Regardless of its source, we will evaluate every medical opinion we receive. Unless we give a treating source's opinion controlling weight under paragraph (d)(2) of this section, we consider all of the following factors in deciding the weight we give to any medical opinion.

(1) *Examining relationship.* Generally, we give more weight to the opinion of a source who has examined you than to the opinion of a source who has not examined you.

(2) *Treatment relationship.* Generally, we give more weight to opinions from your treating sources, since these sources are likely to be the medical professionals most able to provide a detailed, longitudinal picture of your medical impairment(s) and may bring a

unique perspective to the medical evidence that cannot be obtained from the objective medical findings alone or from reports of individual examinations, such as consultative examinations or brief hospitalizations. If we find that a treating source's opinion on the issue(s) of the nature and severity of your impairment(s) is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in your case record, we will give it controlling weight. When we do not give the treating source's opinion controlling weight, we apply the factors listed in paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) 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. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.*,

that would direct the determination or decision of disability.

(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 Commissioner.* 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 medical 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 this subpart, your residual functional capacity (see §§ 404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) *Opinions of nonexamining sources.* We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult in connection with administrative law judge hearings and Appeals Council review:

(1) At the initial and reconsideration steps in the administrative review process, except in disability hearings, State agency medical and psychological consultants are members of the teams that make the determinations of disability. A State agency medical or psychological consultant will consider the evidence in your case record and make findings of fact about the medical issues, including, but not limited to, the existence and severity of your impairment(s), the existence and severity of your symptoms, whether your impairment(s) meets or equals the requirements for any impairment listed in appendix 1 to this subpart, and your residual functional capacity. These administrative findings of fact are based on the evidence in your case record but are not themselves evidence at these steps.

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See § 404.1512(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or

psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to this subpart. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(3) When the Appeals Council makes a decision, it will follow the same rules for considering opinion evidence as administrative law judges follow.

[56 FR 36960, Aug. 1, 1991, as amended at 62 FR 38451, July 18, 1997; 65 FR 11877, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11877, Mar. 7, 2000, §404.1527 was amended by revising the section heading, the third sentence of paragraph (d)(2), the heading of paragraph (e), paragraph (e)(2), the heading and introductory text of paragraph (f), and paragraph (f)(2), by adding a sentence to the end of paragraph (d)(6), by adding introductory text to paragraph (e), and by adding paragraph (e)(3), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§404.1527 Evaluating medical opinions about your impairment(s) or disability.

* * * * *

(d) * * *

(2) * * * 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. * * *

* * * * *

(e) *Medical source opinions on issues reserved to the Commissioner*— * * *

* * * * *

(2) *Other opinions on issues reserved to the Commissioner.* We use medical sources, including your treating source, to provide evidence, including opinions, on the nature and severity of your impairment(s). Although we consider opinions from treating and examining sources on issues such as whether your impairment(s) meets or equals the requirements of any impairment(s) in the Listing of Impairments in appendix 1 of this subpart, your residual functional capacity (see §§404.1545 and 404.1546), or the application of vocational factors, the final responsibility for deciding these issues is reserved to the Commissioner. 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.

* * * * *

(2) Administrative law judges are responsible for reviewing the evidence and making findings of fact and conclusions of law. Administrative law judges are not bound by any findings made by State agency medical or psychological consultants. However, these findings are considered at the hearing level. See §404.1512(b)(6). When administrative law judges consider these findings, they will evaluate them using the rules set forth in paragraphs (a) through (e) of this section. Also, administrative law judges may ask for and consider the opinions of medical advisors on the nature and severity of your impairment(s) and whether your impairment(s) equals the requirements of any listed impairment in appendix 1 to this subpart.

* * * * *

§404.1528 Symptoms, signs, and laboratory findings.

Medical findings consist of symptoms, signs, and laboratory findings:

(a) *Symptoms* are your own description of your physical or mental impairment. Your statements alone are not enough to establish that there is a physical or mental impairment.

(b) *Signs* are anatomical, physiological, or psychological abnormalities which can be observed, apart from your statements (symptoms). Signs must be shown by medically acceptable clinical diagnostic techniques. Pyschiatric

signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(c) *Laboratory findings* are anatomical, physiological, or psychological phenomena which can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (X-rays), and psychological tests.

§ 404.1529 How we evaluate symptoms, including pain.

(a) *General.* In determining whether you are disabled, we consider all your symptoms, including pain, and the extent to which your symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence. By objective medical evidence, we mean medical signs and laboratory findings as defined in § 404.1528 (b) and (c). By other evidence, we mean the kinds of evidence described in §§ 404.1512(b) (2) through (6) and 404.1513(b) (1), (4), and (5) and (e). These include statements or reports from you, your treating or examining physician or psychologist, and others about your medical history, diagnosis, prescribed treatment, daily activities, efforts to work, and any other evidence showing how your impairment(s) and any related symptoms affect your ability to work. We will consider all of your statements about your symptoms, such as pain, and any description you, your physician, your psychologist, or other persons may provide about how the symptoms affect your activities of daily living and your ability to work. However, statements about your pain or other symptoms will not alone establish that you are disabled; there must be medical signs and laboratory findings which show that you have a medical impairment(s) which could reasonably be expected to produce the pain or other symptoms alleged and which, when considered with all of the other evidence (including statements about the intensity and persistence of your pain or other symptoms which may reasonably be accepted as consistent with the medical signs and laboratory findings), would lead to a conclusion that you are disabled. In evaluating the intensity and persistence of your symptoms, including pain, we will consider all of the available evidence, including your medical history, the medical signs and laboratory findings and statements about how your symptoms affect you. (Section 404.1527 explains how we consider opinions of your treating source and other medical opinions on the existence and severity of your symptoms, such as pain.) We will then determine the extent to which your alleged functional limitations and restrictions due to pain or other symptoms can reasonably be accepted as consistent with the medical signs and laboratory findings and other evidence to decide how your symptoms affect your ability to work.

(b) *Need for medically determinable impairment that could reasonably be expected to produce your symptoms, such as pain.* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, will not be found to affect your ability to do basic work activities unless medical signs or laboratory findings show that a medically determinable impairment(s) is present. Medical signs and laboratory findings, established by medically acceptable clinical or laboratory diagnostic techniques, must show the existence of a medical impairment(s) which results from anatomical, physiological, or psychological abnormalities and which could reasonably be expected to produce the pain or other symptoms alleged. At the initial or reconsideration step in the administrative review process (except in disability hearings), a State agency medical or psychological consultant (or other medical or psychological consultant designated by the Commissioner) directly participates in determining whether your medically determinable impairment(s) could reasonably be expected to produce your alleged symptoms. In the disability hearing process, a medical or psychological consultant may provide an advisory assessment to assist a disability hearing officer in determining whether your

impairment(s) could reasonably be expected to produce your alleged symptoms. At the administrative law judge hearing or Appeals Council level, the administrative law judge or the Appeals Council may ask for and consider the opinion of a medical advisor concerning whether your impairment(s) could reasonably be expected to produce your alleged symptoms. The finding that your impairment(s) could reasonably be expected to produce your pain or other symptoms does not involve a determination as to the intensity, persistence, or functionally limiting effects of your symptoms. We will develop evidence regarding the possibility of a medically determinable mental impairment when we have information to suggest that such an impairment exists, and you allege pain or other symptoms but the medical signs and laboratory findings do not substantiate any physical impairment(s) capable of producing the pain or other symptoms.

(c) *Evaluating the intensity and persistence of your symptoms, such as pain, and determining the extent to which your symptoms limit your capacity for work*—(1) *General.* When the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain, we must then evaluate the intensity and persistence of your symptoms so that we can determine how your symptoms limit your capacity for work. In evaluating the intensity and persistence of your symptoms, we consider all of the available evidence, including your medical history, the medical signs and laboratory findings, and statements from you, your treating or examining physician or psychologist, or other persons about how your symptoms affect you. We also consider the medical opinions of your treating source and other medical opinions as explained in §404.1527. Paragraphs (c)(2) through (c)(4) of this section explain further how we evaluate the intensity and persistence of your symptoms and how we determine the extent to which your symptoms limit your capacity for work, when the medical signs or laboratory findings show that you have a medically determinable impairment(s) that could reasonably be expected to produce your symptoms, such as pain.

(2) *Consideration of objective medical evidence.* Objective medical evidence is evidence obtained from the application of medically acceptable clinical and laboratory diagnostic techniques, such as evidence of reduced joint motion, muscle spasm, sensory deficit or motor disruption. Objective medical evidence of this type is a useful indicator to assist us in making reasonable conclusions about the intensity and persistence of your symptoms and the effect those symptoms, such as pain, may have on your ability to work. We must always attempt to obtain objective medical evidence and, when it is obtained, we will consider it in reaching a conclusion as to whether you are disabled. However, we will not reject your statements about the intensity and persistence of your pain or other symptoms or about the effect your symptoms have on your ability to work solely because the available objective medical evidence does not substantiate your statements.

(3) *Consideration of other evidence.* Since symptoms sometimes suggest a greater severity of impairment than can be shown by objective medical evidence alone, we will carefully consider any other information you may submit about your symptoms. The information that you, your treating or examining physician or psychologist, or other persons provide about your pain or other symptoms (e.g., what may precipitate or aggravate your symptoms, what medications, treatments or other methods you use to alleviate them, and how the symptoms may affect your pattern of daily living) is also an important indicator of the intensity and persistence of your symptoms. Because symptoms, such as pain, are subjective and difficult to quantify, any symptom-related functional limitations and restrictions which you, your treating or examining physician or psychologist, or other persons report, which can reasonably be accepted as consistent with the objective medical evidence and other evidence, will be taken into account as explained in paragraph (c)(4) of this section in reaching a conclusion as to whether you are disabled. We will consider all of the evidence

presented, including information about your prior work record, your statements about your symptoms, evidence submitted by your treating, examining or consulting physician or psychologist, and observations by our employees and other persons. Section 404.1527 explains in detail how we consider and weigh treating source and other medical opinions about the nature and severity of your impairment(s) and any related symptoms, such as pain. Factors relevant to your symptoms, such as pain, which we will consider include:

(i) Your daily activities;

(ii) The location, duration, frequency, and intensity of your pain or other symptoms;

(iii) Precipitating and aggravating factors;

(iv) The type, dosage, effectiveness, and side effects of any medication you take or have taken to alleviate your pain or other symptoms;

(v) Treatment, other than medication, you receive or have received for relief of your pain or other symptoms;

(vi) Any measures you use or have used to relieve your pain or other symptoms (e.g., lying flat on your back, standing for 15 to 20 minutes every hour, sleeping on a board, etc.); and

(vii) Other factors concerning your functional limitations and restrictions due to pain or other symptoms.

(4) *How we determine the extent to which symptoms, such as pain, affect your capacity to perform basic work activities.* In determining the extent to which your symptoms, such as pain, affect your capacity to perform basic work activities, we consider all of the available evidence described in paragraphs (c)(1) through (c)(3) of this section. We will consider your statements about the intensity, persistence, and limiting effects of your symptoms, and we will evaluate your statements in relation to the objective medical evidence and other evidence, in reaching a conclusion as to whether you are disabled. We will consider whether there are any inconsistencies in the evidence and the extent to which there are any conflicts between your statements and the rest of the evidence, including your medical history, the medical signs and laboratory findings, and statements by your treating or examining physician or psychologist or other persons about how your symptoms affect you. Your symptoms, including pain, will be determined to diminish your capacity for basic work activities to the extent that your alleged functional limitations and restrictions due to symptoms, such as pain, can reasonably be accepted as consistent with the objective medical evidence and other evidence.

(d) *Consideration of symptoms in the disability determination process.* We follow a set order of steps to determine whether you are disabled. If you are not doing substantial gainful activity, we consider your symptoms, such as pain, to evaluate whether you have a severe physical or mental impairment(s), and at each of the remaining steps in the process. Sections 404.1520 and 404.1520a explain this process in detail. We also consider your symptoms, such as pain, at the appropriate steps in our review when we consider whether your disability continues. Sections 404.1579 and 404.1594 explain the procedure we follow in reviewing whether your disability continues.

(1) *Need to establish a severe medically determinable impairment(s).* Your symptoms, such as pain, fatigue, shortness of breath, weakness, or nervousness, are considered in making a determination as to whether your impairment or combination of impairment(s) is severe. (See § 404.1520(c).)

(2) *Decision whether the Listing of Impairments is met.* Some listed impairment(s) include symptoms, such as pain, as criteria. Section 404.1525(f) explains how we consider your symptoms when your symptoms are included as criteria for a listed impairment.

(3) *Decision whether the Listing of Impairments is equaled.* If your impairment is not the same as a listed impairment, we must determine whether your impairment(s) is medically equivalent to a listed impairment. Section 404.1526 explains how we make this determination. Under § 404.1526(b), we will consider equivalence based on medical evidence only. In considering whether your symptoms, signs, and laboratory findings are medically equal to the symptoms, signs, and laboratory findings of a listed impairment, we will look to see whether your symptoms,

signs, and laboratory findings are at least equal in severity to the listed criteria. However, we will not substitute your allegations of pain or other symptoms for a missing or deficient sign or laboratory finding to raise the severity of your impairment(s) to that of a listed impairment. If the symptoms, signs, and laboratory findings of your impairment(s) are equivalent in severity to those of a listed impairment, we will find you disabled. If it does not, we will consider the impact of your symptoms on your residual functional capacity. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity.* If you have a medically determinable severe physical or mental impairment(s), but your impairment(s) does not meet or equal an impairment listed in appendix 1 of this subpart, we will consider the impact of your impairment(s) and any related symptoms, including pain, on your residual functional capacity. (See §404.1545.)

[56 FR 57941, Nov. 14, 1991, as amended at 62 FR 38451, July 18, 1997]

§404.1530 Need to follow prescribed treatment.

(a) *What treatment you must follow.* In order to get benefits, you must follow treatment prescribed by your physician if this treatment can restore your ability to work.

(b) *When you do not follow prescribed treatment.* If you do not follow the prescribed treatment without a good reason, we will not find you disabled or, if you are already receiving benefits, we will stop paying you benefits.

(c) *Acceptable reasons for failure to follow prescribed treatment.* We will consider your physical, mental, educational, and linguistic limitations (including any lack of facility with the English language) when determining if you have an acceptable reason for failure to follow prescribed treatment. The following are examples of a good reason for not following treatment:

(1) The specific medical treatment is contrary to the established teaching and tenets of your religion.

(2) The prescribed treatment would be cataract surgery for one eye, when there is an impairment of the other eye resulting in a severe loss of vision and is not subject to improvement through treatment.

(3) Surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.

(4) The treatment because of its magnitude (e.g. open heart surgery), unusual nature (e.g., organ transplant), or other reason is very risky for you; or

(5) The treatment involves amputation of an extremity, or a major part of an extremity.

[45 FR 55584, Aug. 20, 1980, as amended at 59 FR 1635, Jan. 12, 1994]

§404.1535 How we will determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) *General.* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) *Process we will follow when we have medical evidence of your drug addiction or alcoholism.* (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will

find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

[60 FR 8147, Feb. 10, 1995]

§ 404.1536 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.

(a) If we determine that you are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in § 404.1535), you must avail yourself of appropriate treatment for your drug addiction or alcoholism at an institution or facility approved by us when this treatment is available and make progress in your treatment. Generally, you are not expected to pay for this treatment. You will not be paid benefits for any month after the month we have notified you in writing that—

(1) You did not comply with the terms, conditions and requirements of the treatment which has been made available to you; or

(2) You did not avail yourself of the treatment after you had been notified that it is available to you.

(b) If your benefits are suspended for failure to comply with treatment requirements, your benefits can be reinstated in accordance with the rules in § 404.470.

[60 FR 8147, Feb. 10, 1995]

§ 404.1537 What we mean by appropriate treatment.

By appropriate treatment, we mean treatment for drug addiction or alcoholism that serves the needs of the individual in the least restrictive setting possible consistent with your treatment plan. These settings range from outpatient counseling services through a variety of residential treatment settings including acute detoxification, short-term intensive residential treatment, long-term therapeutic residential treatment, and long-term recovery houses. Appropriate treatment is determined with the involvement of a State licensed or certified addiction professional on the basis of a detailed assessment of the individual's presenting symptomatology, psychosocial profile, and other relevant factors. This assessment may lead to a determination that more than one treatment modality is appropriate for the individual. The treatment will be provided or overseen by an approved institution or facility. This treatment may include (but is not limited to)—

(a) Medical examination and medical management;

(b) Detoxification;

(c) Medication management to include substitution therapy (e.g., methadone);

(d) Psychiatric, psychological, psychosocial, vocational, or other substance abuse counseling in a residential or outpatient treatment setting; or

(e) Relapse prevention.

[60 FR 8148, Feb. 10, 1995]

§ 404.1538 What we mean by approved institutions or facilities.

Institutions or facilities that we may approve include—

(a) An institution or facility that furnishes medically recognized treatment for drug addiction or alcoholism in conformity with applicable Federal or State laws and regulations;

(b) An institution or facility used by or licensed by an appropriate State agency which is authorized to refer persons for treatment of drug addiction or alcoholism;

(c) State licensed or certified care providers;

(d) Programs accredited by the Commission on Accreditation for Rehabilitation Facilities (CARF) and/or the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for the treatment of drug addiction or alcoholism;

(e) Medicare or Medicaid certified care providers; or

(f) Nationally recognized self-help drug addiction or alcoholism recovery programs (e.g., Alcoholics Anonymous or Narcotics Anonymous) when participation in these programs is specifically prescribed by a treatment professional at an institution or facility described in paragraphs (a) through (e) of this section as part of an individual's treatment plan.

[60 FR 8148, Feb. 10, 1995]

§404.1539 How we consider whether treatment is available.

Our determination about whether treatment is available to you for your drug addiction or your alcoholism will depend upon—

(a) The capacity of an approved institution or facility to admit you for appropriate treatment;

(b) The location of the approved institution or facility, or the place where treatment, services or resources could be provided to you;

(c) The availability and cost of transportation for you to the place of treatment;

(d) Your general health, including your ability to travel and capacity to understand and follow the prescribed treatment;

(e) Your particular condition and circumstances; and

(f) The treatment that is prescribed for your drug addiction or alcoholism.

[60 FR 8148, Feb. 10, 1995]

§404.1540 Evaluating compliance with the treatment requirements.

(a) *General.* Generally, we will consider information from the treatment institution or facility to evaluate your compliance with your treatment plan. The treatment institution or facility will:

(1) Monitor your attendance at and participation in treatment sessions;

(2) Provide reports of the results of any clinical testing (such as, hematological or urinalysis studies for individuals with drug addiction and hematological studies and breath analysis for individuals with alcoholism) when such tests are likely to yield important information;

(3) Provide observational reports from the treatment professionals familiar with your individual case (subject to verification and Federal confidentiality requirements); or

(4) Provide their assessment or views on your noncompliance with treatment requirements.

(b) *Measuring progress.* Generally, we will consider information from the treatment institution or facility to evaluate your progress in completing your treatment plan. Examples of milestones for measuring your progress with the treatment which has been prescribed for your drug addiction or alcoholism may include (but are not limited to)—

(1) Abstinence from drug or alcohol use (initial progress may include significant reduction in use);

(2) Consistent attendance at and participation in treatment sessions;

(3) Improved social functioning and levels of gainful activity;

(4) Participation in vocational rehabilitation activities; or

(5) Avoidance of criminal activity.

[60 FR 8148, Feb. 10, 1995]

§404.1541 Establishment and use of referral and monitoring agencies.

We will contract with one or more agencies in each of the States, Puerto Rico and the District of Columbia to provide services to individuals whose disabilities are based on a determination that drug addiction or alcoholism is a contributing factor material to the determination of disability (as described in §404.1535) and to submit information to us which we will use to make decisions about these individuals' benefits. These agencies will be known as referral and monitoring agencies. Their duties and responsibilities include (but are not limited to)—

(a) Identifying appropriate treatment placements for individuals we refer to them;

(b) Referring these individuals for treatment;

(c) Monitoring the compliance and progress with the appropriate treatment of these individuals; and

(d) Promptly reporting to us any individual's failure to comply with treatment requirements as well as failure to achieve progress through the treatment.

[60 FR 8148, Feb. 10, 1995]

RESIDUAL FUNCTIONAL CAPACITY

§404.1545 Your residual functional capacity.

(a) *General.* Your impairment(s), and any related symptoms, such as pain, may cause physical and mental limitations that affect what you can do in a work setting. Your residual functional capacity is what you can still do despite your limitations. If you have more than one impairment, we will

consider all of your impairment(s) of which we are aware. We will consider your ability to meet certain demands of jobs, such as physical demands, mental demands, sensory requirements, and other functions, as described in paragraphs (b), (c), and (d) of this section. Residual functional capacity is an assessment based upon all of the relevant evidence. It may include descriptions (even your own) of limitations that go beyond the symptoms, such as pain, that are important in the diagnosis and treatment of your medical condition. Observations by your treating or examining physicians or psychologists, your family, neighbors, friends, or other persons, of your limitations, in addition to those observations usually made during formal medical examinations, may also be used. These descriptions and observations, when used, must be considered along with your medical records to enable us to decide to what extent your impairment(s) keeps you from performing particular work activities. This assessment of your remaining capacity for work is not a decision on whether you are disabled, but is used as the basis for determining the particular types of work you may be able to do despite your impairment(s). Then, using the guidelines in §§ 404.1560 through 404.1569a, your vocational background is considered along with your residual functional capacity in arriving at a disability determination or decision. In deciding whether your disability continues or ends, the residual functional capacity assessment may also be used to determine whether any medical improvement you have experienced is related to your ability to work as discussed in § 404.1594.

(b) *Physical abilities.* When we assess your physical abilities, we first assess the nature and extent of your physical limitations and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to perform certain physical demands of work activity, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping or crouching), may reduce your ability to do past work and other work.

(c) *Mental abilities.* When we assess your mental abilities, we first assess the nature and extent of your mental limitations and restrictions and then determine your residual functional capacity for work activity on a regular and continuing basis. A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work.

(d) *Other abilities affected by impairment(s).* Some medically determinable impairment(s), such as skin impairment(s), epilepsy, impairment(s) of vision, hearing or other senses, and impairment(s) which impose environmental restrictions, may cause limitations and restrictions which affect other work-related abilities. If you have this type of impairment(s), we consider any resulting limitations and restrictions which may reduce your ability to do past work and other work in deciding your residual functional capacity.

(e) *Total limiting effects.* When you have a severe impairment(s), but your symptoms, signs, and laboratory findings do not meet or equal those of a listed impairment in appendix 1 of this subpart, we will consider the limiting effects of all your impairment(s), even those that are not severe, in determining your residual functional capacity. Pain or other symptoms may cause a limitation of function beyond that which can be determined on the basis of the anatomical, physiological or psychological abnormalities considered alone; e.g., someone with a low back disorder may be fully capable of the physical demands consistent with those of sustained medium work activity, but another person with the same disorder, because of pain, may not be capable of more than the physical demands consistent with those of light work activity on a sustained basis. In assessing the total limiting effects of your impairment(s) and any related symptoms, we will consider all of the

medical and nonmedical evidence, including the information described in §404.1529(c).

[56 FR 57943, Nov, 14, 1991]

§404.1546 Responsibility for assessing and determining residual functional capacity.

The State agency staff medical or psychological consultants or other medical or psychological consultants designated by the Commissioner 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 Commissioner. See §404.1545. For cases in the disability hearing process, the responsibility for deciding your residual functional capacity rests with either the disability hearing officer or, if the disability hearing officer's reconsidered determination is changed under §404.918, with the Director of the Office of Disability Hearings or his or her delegate. For cases at the Administrative Law Judge hearing or Appeals Council level, the responsibility for deciding your residual functional capacity rests with the Administrative Law Judge or Appeals Council.

[56 FR 36962, Aug. 1, 1991, as amended at 62 FR 38451, July 18, 1997]

VOCATIONAL CONSIDERATIONS

§404.1560 When your vocational background will be considered.

(a) *General.* If you are applying for a period of disability, or disability insurance benefits as a disabled worker, or child's insurance benefits based on disability which began before age 22, or widow's or widower's benefits based on disability for months after December 1990, and we cannot decide whether you are disabled on medical evidence alone, we will consider your residual functional capacity together with your vocational background.

(b) *Past relevant work.* We will first compare your residual functional capacity with the physical and mental demands of the kind of work you have done in the past. If you still have the residual functional capacity to do your past relevant work, we will find that you can still do your past work, and we will determine that you are not disabled, without considering your vocational factors of age, education, and work experience.

(c) *Other work.* If we find that you can no longer do the kind of work you have done in the past, we will then consider your residual functional capacity together with your vocational factors of age, education, and work experience to determine whether you can do other work. By other work we mean jobs that exist in significant numbers in the national economy.

[55 FR 11011, Mar. 26, 1990, as amended at 57 FR 30120, July 8, 1992]

§404.1561 Your ability to do work depends upon your residual functional capacity.

If you can do your previous work (your usual work or other applicable past work), we will determine that you are not disabled. However, if your residual functional capacity is not enough to enable you to do any of your previous work, we must still decide if you can do any other work. To do this, we consider your residual functional capacity, and your age, education, and work experience. Any work (jobs) that you can do must exist in significant numbers in the national economy (either in the region where you live or in several regions of the country). Sections 404.1563 through 404.1565 explain how we evaluate your age, education, and work experience when we are deciding whether or not you are able to do other work.

§404.1562 If you have done only arduous unskilled physical labor.

If you have only a marginal education and work experience of 35 years or more during which you did arduous unskilled physical labor, and you are not working and are no longer able to

do this kind of work because of a severe impairment(s), we will consider you unable to do lighter work, and therefore, disabled. However, if you are working or have worked despite your impairment(s) (except where the work is sporadic or is not medically advisable), we will review all the facts in your case, and we may find that you are not disabled. In addition, we will consider that you are not disabled if the evidence shows that you have training or past work experience which enables you to do substantial gainful activity in another occupation with your impairment, either on a full-time or a reasonably regular part-time basis.

Example: B is a 60-year-old miner with a fourth grade education who has a life-long history of arduous physical labor. B says that he is disabled because of arthritis of the spine, hips, and knees, and other impairments. Medical evidence shows a combination of impairments and establishes that these impairments prevent B from performing his usual work or any other type of arduous physical labor. His vocational background does not show that he has skills or capabilities needed to do lighter work which would be readily transferable to another work setting. Under these circumstances, we will find that B is disabled.

§ 404.1563 Your age as a vocational factor.

(a) *General. Age* refers to how old you are (your chronological age) and the extent to which your age affects your ability to adapt to a new work situation and to do work in competition with others. However, we do not determine disability on your age alone. We must also consider your residual functional capacity, education, and work experience. If you are unemployed because of your age and you can still do a significant number of jobs which exist in the national economy, we will find that you are not disabled. We explain in detail how we consider your age as a vocational factor in appendix 2. However, we will not apply these age categories mechanically in a borderline situation.

(b) *Younger person.* If you are under age 50, we generally do not consider that your age will seriously affect your ability to adapt to a new work situation. In some circumstances, however, we consider age 45 a handicap in adapting to a new work setting (see Rule 201.17 in appendix 2).

(c) *Person approaching advanced age.* If you are closely approaching advanced age (50–54), we will consider that your age, along with a severe impairment and limited work experience, may seriously affect your ability to adjust to a significant number of jobs in the national economy.

(d) *Person of advanced age.* We consider that advanced age (55 or over) is the point where age significantly affects a person's ability to do substantial gainful activity. If you are severely impaired and of advanced age and you cannot do medium work (see § 404.1567(c)), you may not be able to work unless you have skills that can be used in (transferred to) less demanding jobs which exist in significant numbers in the national economy. If you are close to retirement age (60–64) and have a severe impairment, we will not consider you able to adjust to sedentary or light work unless you have skills which are highly marketable.

(e) *Information about your age.* We will usually not ask you to prove your age. However, if we need to know your exact age to determine whether you get disability benefits or if the amount of your benefit will be affected, we will ask you for evidence of your age.

§ 404.1564 Your education as a vocational factor.

(a) *General. Education* is primarily used to mean formal schooling or other training which contributes to your ability to meet vocational requirements, for example, reasoning ability, communication skills, and arithmetical ability. However, if you do not have formal schooling, this does not necessarily mean that you are uneducated or lack these abilities. Past work experience and the kinds of responsibilities you had when you were working may show that you have intellectual abilities, although you may have little formal education. Your daily activities, hobbies, or the results of testing may also show that you have significant intellectual ability that can be used to work.

(b) *How we evaluate your education.* The importance of your educational

background may depend upon how much time has passed between the completion of your formal education and the beginning of your physical or mental impairment(s) and by what you have done with your education in a work or other setting. Formal education that you completed many years before your impairment began, or unused skills and knowledge that were a part of your formal education, may no longer be useful or meaningful in terms of your ability to work. Therefore, the numerical grade level that you completed in school may not represent your actual educational abilities. These may be higher or lower. However, if there is no other evidence to contradict it, we will use your numerical grade level to determine your educational abilities. The term *education* also includes how well you are able to communicate in English since this ability is often acquired or improved by education. In evaluating your educational level, we use the following categories:

(1) *Illiteracy*. Illiteracy means the inability to read or write. We consider someone illiterate if the person cannot read or write a simple message such as instructions or inventory lists even though the person can sign his or her name. Generally, an illiterate person has had little or no formal schooling.

(2) *Marginal education*. Marginal education means ability in reasoning, arithmetic, and language skills which are needed to do simple, unskilled types of jobs. We generally consider that formal schooling at a 6th grade level or less is a marginal education.

(3) *Limited education*. Limited education means ability in reasoning, arithmetic, and language skills, but not enough to allow a person with these educational qualifications to do most of the more complex job duties needed in semi-skilled or skilled jobs. We generally consider that a 7th grade through the 11th grade level of formal education is a limited education.

(4) *High school education and above*. High school education and above means abilities in reasoning, arithmetic, and language skills acquired through formal schooling at a 12th grade level or above. We generally consider that someone with these educational abilities can do semi-skilled through skilled work.

(5) *Inability to communicate in English*. Since the ability to speak, read and understand English is generally learned or increased at school, we may consider this an educational factor. Because English is the dominant language of the country, it may be difficult for someone who doesn't speak and understand English to do a job, regardless of the amount of education the person may have in another language. Therefore, we consider a person's ability to communicate in English when we evaluate what work, if any, he or she can do. It generally doesn't matter what other language a person may be fluent in.

(6) *Information about your education*. We will ask you how long you attended school and whether you are able to speak, understand, read and write in English and do at least simple calculations in arithmetic. We will also consider other information about how much formal or informal education you may have had through your previous work, community projects, hobbies, and any other activities which might help you to work.

§404.1565 Your work experience as a vocational factor.

(a) *General. Work experience* means skills and abilities you have acquired through work you have done which show the type of work you may be expected to do. Work you have already been able to do shows the kind of work that you may be expected to do. We consider that your work experience applies when it was done within the last 15 years, lasted long enough for you to learn to do it, and was substantial gainful activity. We do not usually consider that work you did 15 years or more before the time we are deciding whether you are disabled (or when the disability insured status requirement was last met, if earlier) applies. A gradual change occurs in most jobs so that after 15 years it is no longer realistic to expect that skills and abilities acquired in a job done then continue to apply. The 15-year guide is intended to insure that remote work experience is not currently applied. If you have no work experience or worked only ''off-

and-on'' or for brief periods of time during the 15-year period, we generally consider that these do not apply. If you have acquired skills through your past work, we consider you to have these work skills unless you cannot use them in other skilled or semi-skilled work that you can now do. If you cannot use your skills in other skilled or semi-skilled work, we will consider your work background the same as unskilled. However, even if you have no work experience, we may consider that you are able to do unskilled work because it requires little or no judgment and can be learned in a short period of time.

(b) *Information about your work.* Under certain circumstances, we will ask you about the work you have done in the past. If you cannot give us all of the information we need, we will try, with your permission, to get it from your employer or other person who knows about your work, such as a member of your family or a co-worker. When we need to consider your work experience to decide whether you are able to do work that is different from what you have done in the past, we will ask you to tell us about all of the jobs you have had in the last 15 years. You must tell us the dates you worked, all of the duties you did, and any tools, machinery, and equipment you used. We will need to know about the amount of walking, standing, sitting, lifting and carrying you did during the work day, as well as any other physical or mental duties of your job. If all of your work in the past 15 years has been arduous and unskilled, and you have very little education, we will ask you to tell us about all of your work from the time you first began working. This information could help you to get disability benefits.

§ 404.1566 Work which exists in the national economy.

(a) *General.* We consider that work exists in the national economy when it exists in significant numbers either in the region where you live or in several other regions of the country. It does not matter whether—

(1) Work exists in the immediate area in which you live;

(2) A specific job vacancy exists for you; or

(3) You would be hired if you applied for work.

(b) *How we determine the existence of work.* Work exists in the national economy when there is a significant number of jobs (in one or more occupations) having requirements which you are able to meet with your physical or mental abilities and vocational qualifications. Isolated jobs that exist only in very limited numbers in relatively few locations outside of the region where you live are not considered ''work which exists in the national economy''. We will not deny you disability benefits on the basis of the existence of these kinds of jobs. If work that you can do does not exist in the national economy, we will determine that you are disabled. However, if work that you can do does exist in the national economy, we will determine that you are not disabled.

(c) *Inability to obtain work.* We will determine that you are not disabled if your residual functional capacity and vocational abilities make it possible for you to do work which exists in the national economy, but you remain unemployed because of—

(1) Your inability to get work;

(2) Lack of work in your local area;

(3) The hiring practices of employers;

(4) Technological changes in the industry in which you have worked;

(5) Cyclical economic conditions;

(6) No job openings for you;

(7) You would not actually be hired to do work you could otherwise do; or

(8) You do not wish to do a particular type of work.

(d) *Administrative notice of job data.* When we determine that unskilled, sedentary, light, and medium jobs exist in the national economy (in significant numbers either in the region where you live or in several regions of the country), we will take administrative notice of reliable job information available from various governmental and other publications. For example, we will take notice of—

(1) *Dictionary of Occupational Titles,* published by the Department of Labor;

(2) *County Business Patterns,* published by the Bureau of the Census;

(3) *Census Reports,* also published by the Bureau of the Census;

(4) *Occupational Analyses,* prepared for the Social Security Administration by various State employment agencies; and

(5) *Occupational Outlook Handbook,* published by the Bureau of Labor Statistics.

(e) *Use of vocational experts and other specialists.* If the issue in determining whether you are disabled is whether your work skills can be used in other work and the specific occupations in which they can be used, or there is a similarly complex issue, we may use the services of a vocational expert or other specialist. We will decide whether to use a vocational expert or other specialist.

§ 404.1567 Physical exertion requirements.

To determine the physical exertion requirements of work in the national economy, we classify jobs as *sedentary, light, medium, heavy,* and *very heavy.* These terms have the same meaning as they have in the *Dictionary of Occupational Titles,* published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) *Sedentary work.* Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) *Light work.* Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) *Medium work.* Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) *Heavy work.* Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) *Very heavy work.* Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light and sedentary work.

§ 404.1568 Skill requirements.

In order to evaluate your skills and to help determine the existence in the national economy of work you are able to do, occupations are classified as unskilled, semi-skilled, and skilled. In classifying these occupations, we use materials published by the Department of Labor. When we make disability determinations under this subpart, we use the following definitions:

(a) *Unskilled work.* Unskilled work is work which needs little or no judgment to do simple duties that can be learned on the job in a short period of time. The job may or may not require considerable strength. For example, we consider jobs unskilled if the primary work duties are handling, feeding and offbearing (that is, placing or removing materials from machines which are automatic or operated by others), or machine tending, and a person can usually learn to do the job in 30 days, and little specific vocational preparation and judgment are needed. A person does not gain work skills by doing unskilled jobs.

(b) *Semi-skilled work.* Semi-skilled work is work which needs some skills but does not require doing the more

complex work duties. Semi-skilled jobs may require alertness and close attention to watching machine processes; or inspecting, testing or otherwise looking for irregularities; or tending or guarding equipment, property, materials, or persons against loss, damage or injury; or other types of activities which are similarly less complex than skilled work, but more complex than unskilled work. A job may be classified as semi-skilled where coordination and dexterity are necessary, as when hands or feet must be moved quickly to do repetitive tasks.

(c) *Skilled work.* Skilled work requires qualifications in which a person uses judgment to determine the machine and manual operations to be performed in order to obtain the proper form, quality, or quantity of material to be produced. Skilled work may require laying out work, estimating quality, determining the suitability and needed quantities of materials, making precise measurements, reading blueprints or other specifications, or making necessary computations or mechanical adjustments to control or regulate the work. Other skilled jobs may require dealing with people, facts, or figures or abstract ideas at a high level of complexity.

(d) *Skills that can be used in other work (transferability)*—(1) *What we mean by transferable skills.* We consider you to have skills that can be used in other jobs, when the skilled or semi-skilled work activities you did in past work can be used to meet the requirements of skilled or semi-skilled work activities of other jobs or kinds of work. This depends largely on the similarity of occupationally significant work activities among different jobs.

(2) *How we determine skills that can be transferred to other jobs.* Transferability is most probable and meaningful among jobs in which—

(i) The same or a lesser degree of skill is required;

(ii) The same or similar tools and machines are used; and

(iii) The same or similar raw materials, products, processes, or services are involved.

(3) *Degrees of transferability.* There are degrees of transferability of skills ranging from very close similarities to remote and incidental similarities among jobs. A complete similarity of all three factors is not necessary for transferability. However, when skills are so specialized or have been acquired in such an isolated vocational setting (like many jobs in mining, agriculture, or fishing) that they are not readily usable in other industries, jobs, and work settings, we consider that they are not transferable.

§ 404.1569 Listing of Medical-Vocational Guidelines in appendix 2.

The Dictionary of Occupational Titles includes information about jobs (classified by their exertional and skill requirements) that exist in the national economy. Appendix 2 provides rules using this data reflecting major functional and vocational patterns. We apply these rules in cases where a person is not doing substantial gainful activity and is prevented by a severe medically determinable impairment from doing vocationally relevant past work. The rules in appendix 2 do not cover all possible variations of factors. Also, as we explain in § 200.00 of appendix 2, we do not apply these rules if one of the findings of fact about the person's vocational factors and residual functional capacity is not the same as the corresponding criterion of a rule. In these instances, we give full consideration to all relevant facts in accordance with the definitions and discussions under vocational considerations. However, if the findings of fact made about all factors are the same as the rule, we use that rule to decide whether a person is disabled.

§ 404.1569a Exertional and nonexertional limitations.

(a) *General.* Your impairment(s) and related symptoms, such as pain, may cause limitations of function or restrictions which limit your ability to meet certain demands of jobs. These limitations may be exertional, nonexertional, or a combination of both. Limitations are classified as exertional if they affect your ability to meet the strength demands of jobs. The classification of a limitation as exertional is related to the United States Department of Labor's classification of jobs by various exertional levels (sedentary,

light, medium, heavy, and very heavy) in terms of the strength demands for sitting, standing, walking, lifting, carrying, pushing, and pulling. Sections 404.1567 and 404.1569 explain how we use the classification of jobs by exertional levels (strength demands) which is contained in the Dictionary of Occupational Titles published by the Department of Labor, to determine the exertional requirements of work which exists in the national economy. Limitations or restrictions which affect your ability to meet the demands of jobs other than the strength demands, that is, demands other than sitting, standing, walking, lifting, carrying, pushing or pulling, are considered nonexertional. Sections 404.1520(f) and 404.1594(f)(8) explain that if you can no longer do your past relevant work because of a severe medically determinable impairment(s), we must determine whether your impairment(s), when considered along with your age, education, and work experience, prevents you from doing any other work which exists in the national economy in order to decide whether you are disabled (§404.1520(f)) or continue to be disabled (§404.1594(f)(8)). Paragraphs (b), (c), and (d) of this section explain how we apply the medical-vocational guidelines in appendix 2 of this subpart in making this determination, depending on whether the limitations or restrictions imposed by your impairment(s) and related symptoms, such as pain, are exertional, nonexertional, or a combination of both.

(b) *Exertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the strength demands of jobs (sitting, standing, walking, lifting, carrying, pushing, and pulling), we consider that you have only exertional limitations. When your impairment(s) and related symptoms only impose exertional limitations and your specific vocational profile is listed in a rule contained in appendix 2 of this subpart, we will directly apply that rule to decide whether you are disabled.

(c) *Nonexertional limitations.* (1) When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect only your ability to meet the demands of jobs other than the strength demands, we consider that you have only nonexertional limitations or restrictions. Some examples of nonexertional limitations or restrictions include the following:

(i) You have difficulty functioning because you are nervous, anxious, or depressed;

(ii) You have difficulty maintaining attention or concentrating;

(iii) You have difficulty understanding or remembering detailed instructions;

(iv) You have difficulty in seeing or hearing;

(v) You have difficulty tolerating some physical feature(s) of certain work settings, e.g., you cannot tolerate dust or fumes; or

(vi) You have difficulty performing the manipulative or postural functions of some work such as reaching, handling, stooping, climbing, crawling, or crouching.

(2) If your impairment(s) and related symptoms, such as pain, only affect your ability to perform the nonexertional aspects of work-related activities, the rules in appendix 2 do not direct factual conclusions of disabled or not disabled. The determination as to whether disability exists will be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in appendix 2.

(d) *Combined exertional and nonexertional limitations.* When the limitations and restrictions imposed by your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we consider that you have a combination of exertional and nonexertional limitations or restrictions. If your impairment(s) and related symptoms, such as pain, affect your ability to meet both the strength and demands of jobs other than the strength demands, we will not directly apply the rules in appendix 2 unless there is a rule that

directs a conclusion that you are disabled based upon your strength limitations; otherwise the rules provide a framework to guide our decision.

[56 FR 57943, Nov, 14, 1991]

SUBSTANTIAL GAINFUL ACTIVITY

§ 404.1571 General.

The work that you have done during any period in which you believe you are disabled may show that you are able to do work at the substantial gainful activity level. If you are able to engage in substantial gainful activity, we will find that you are not disabled. (We explain the rules for persons who are statutorily blind in § 404.1584.) Even if the work you have done was not substantial gainful activity, it may show that you are able to do more work than you actually did. We will consider all of the medical and vocational evidence in your file to decide whether or not you have the ability to engage in substantial gainful activity.

§ 404.1572 What we mean by substantial gainful activity.

Substantial gainful activity is work activity that is both substantial and gainful:

(a) *Substantial work activity.* Substantial work activity is work activity that involves doing significant physical or mental activities. Your work may be substantial even if it is done on a part-time basis or if you do less, get paid less, or have less responsibility than when you worked before.

(b) *Gainful work activity.* Gainful work activity is work activity that you do for pay or profit. Work activity is gainful if it is the kind of work usually done for pay or profit, whether or not a profit is realized.

(c) *Some other activities.* Generally, we do not consider activities like taking care of yourself, household tasks, hobbies, therapy, school attendance, club activities, or social programs to be substantial gainful activity.

§ 404.1573 General information about work activity.

(a) *The nature of your work.* If your duties require use of your experience, skills, supervision and responsibilities, or contribute substantially to the operation of a business, this tends to show that you have the ability to work at the substantial gainful activity level.

(b) *How well you perform.* We consider how well you do your work when we determine whether or not you are doing substantial gainful activity. If you do your work satisfactorily, this may show that you are working at the substantial gainful activity level. If you are unable, because of your impairments, to do ordinary or simple tasks satisfactorily without more supervision or assistance than is usually given other people doing similar work, this may show that you are not working at the substantial gainful activity level. If you are doing work that involves minimal duties that make little or no demands on you and that are of little or no use to your employer, or to the operation of a business if you are self-employed, this does not show that you are working at the substantial gainful activity level.

(c) *If your work is done under special conditions.* Even though the work you are doing takes into account your impairment, such as work done in a sheltered workshop or as a patient in a hospital, it may still show that you have the necessary skills and ability to work at the substantial gainful activity level.

(d) *If you are self-employed.* Supervisory, managerial, advisory or other significant personal services that you perform as a self-employed individual may show that you are able to do substantial gainful activity.

(e) *Time spent in work.* While the time you spend in work is important, we will not decide whether or not you are doing substantial gainful activity only on that basis. We will still evaluate the work to decide whether it is substantial and gainful regardless of whether you spend more time or less time at the job than workers who are not impaired and who are doing similar work as a regular means of their livelihood.

§ 404.1574 Evaluation guides if you are an employee.

(a) *General.* We use several guides to decide whether the work you have done shows that you are able to do substantial gainful activity.

(1) *Your earnings may show you have done substantial gainful activity.* The amount of your earnings from work you have done may show that you have engaged in substantial gainful activity. Generally, if you worked for substantial earnings, this will show that you are able to do substantial gainful activity. On the other hand, the fact that your earnings are not substantial will not necessarily show that you are not able to do substantial gainful activity. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your earnings from that work will not show that you are able to do substantial gainful activity.

(2) *We consider only the amounts you earn.* We do not consider any income not directly related to your productivity when we decide whether you have done substantial gainful activity. If your earnings are being subsidized, the amount of the subsidy is not counted when we determine whether or not your work is substantial gainful activity. Thus, where work is done under special conditions, we only consider the part of your pay which you actually *earn.* For example, where a handicapped person does simple tasks under close and continuous supervision, we would not determine that the person worked at the substantial gainful activity level only on the basis of the amount of pay. An employer may set a specific amount as a subsidy after figuring the reasonable value of the employee's services. If your work is subsidized and your employer does not set the amount of the subsidy or does not adequately explain how the subsidy was figured, we will investigate to see how much your work is worth.

(3) *If you are working in a sheltered or special environment.* If you are working in a sheltered workshop, you may or may not be earning the amounts you are being paid. The fact that the sheltered workshop or similar facility is operating at a loss or is receiving some charitable contributions or governmental aid does not establish that you are not earning all you are being paid. Since persons in military service being treated for severe impairments usually continue to receive full pay, we evaluate work activity in a therapy program or while on limited duty by comparing it with similar work in the civilian work force or on the basis of reasonable worth of the work, rather than on the actual amount of the earnings.

(b) *Earnings guidelines.* (1) *General.* If you are an employee, we first consider the criteria in paragraph (a) of this section and §404.1576, and then the guides in paragraphs (b) (2), (3), (4), (5), and (6) of this section.

(2) *Earnings that will ordinarily show that you have engaged in substantial gainful activity.* We will consider that your earnings from your work activity as an employee show that you have engaged in substantial gainful activity if—

For months	Your monthly earnings averaged more than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
In January 1990–June 1999	500
After June 1999	700

(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—

For months	Your monthly earnings averaged less than:
In calendar years before 1976	$130
In calendar year 1976	150
In calendar year 1977	160
In calendar year 1978	170
In calendar year 1979	180
In calendar years 1980–1989	190
After December 1989	300

(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—

For months	Your average monthly earnings are not greater than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
In January 1990–June 1999	500
After June 1999	700

(5) *If there is evidence showing that you may have done substantial gainful activity.* If there is evidence showing that you may have done substantial gainful activity, we will apply the criteria in paragraph (b)(6) of this section regarding comparability and value of services.

(6) *Earnings that are not high or low enough to show whether you engaged in substantial gainful activity.* If your earnings, on the average, are between the amounts shown in paragraphs (b) (2) and (3) of this section, we will generally consider other information in addition to your earnings, such as whether—

(i) Your work is comparable to that of unimpaired people in your community who are doing the same or similar occupations as their means of livelihood, taking into account the time, energy, skill, and responsibility involved in the work, or

(ii) Your work, although significantly less than that done by unimpaired people, is clearly worth the amounts shown in paragraph (b)(2) of this section, according to pay scales in your community.

[46 FR 4869, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984; 54 FR 53605, Dec. 29, 1989; 64 FR 18570, Apr. 15, 1999; 64 FR 22903, Apr. 28, 1999]

§ 404.1575 Evaluation guides if you are self-employed.

(a) *If you are a self-employed person.* We will consider your activities and their value to your business to decide whether you have engaged in substantial gainful activity if you are self-employed. We will not consider your income alone since the amount of income you actually receive may depend upon a number of different factors like capital investment, profit sharing agreements, etc. We will generally consider work that you are forced to stop after a short time because of your impairment as an unsuccessful work attempt and your income from that work will not show that you are able to do substantial gainful activity. We will evaluate your work activity on the value to the business of your services regardless of whether you receive an immediate income for your services. We consider that you have engaged in substantial gainful activity if—

(1) Your work activity, in terms of factors such as hours, skills, energy output, efficiency, duties, and responsibilities, is comparable to that of unimpaired individuals in your community who are in the same or similar businesses as their means of livelihood;

(2) Your work activity, although not comparable to that of unimpaired individuals, is clearly worth the amount shown in § 404.1574(b)(2) when considered in terms of its value to the business, or when compared to the salary that an owner would pay to an employee to do the work you are doing; or

(3) You render services that are significant to the operation of the business and receive a substantial income from the business.

(b) *What we mean by significant services.* (1) If you are not a farm landlord and you operate a business entirely by yourself, any services that you render are significant to the business. If your business involves the services of more than one person, we will consider you to be rendering significant services if you contribute more than half the total time required for the management of the business, or you render management services for more than 45 hours a month regardless of the total management time required by the business.

(2) If you are a farm landlord, that is, you rent farm land to another, we will consider you to be rendering significant services if you materially particpate in the production or the management of the production of the things raised on the rented farm. (See § 404.1082 of this chapter for an explanation of *material participation.*) If you were given social security earnings credits because you materially participated in the activities of the farm and you continue these same activities, we

will consider you to be rendering significant services.

(c) *What we mean by substantial income.* After your normal business expenses are deducted from your gross income to determine net income, we will deduct the reasonable value of any unpaid help, any soil bank payments that were included as farm income, and impairment-related work expenses described in §404.1576 that have not been deducted in determining your net earnings from self-employment. We will consider the resulting amount of income from the business to be substantial if—

(1) It averages more than the amounts described in §404.1574(b)(2); or

(2) It averages less than the amounts described in §404.1574(b)(2) but the livelihood which you get from the business is either comparable to what it was before you became severely impaired or is comparable to that of unimpaired self-employed persons in your community who are in the same or similar business as their means of livelihood.

[46 FR 4870, Jan. 19, 1981, as amended at 48 FR 21936, May 16, 1983; 49 FR 22272, May 29, 1984]

§404.1576 Impairment-related work expenses.

(a) *General.* When we figure your earnings in deciding if you have done substantial gainful activity, we will subtract the reasonable costs to you of certain items and services which, because of your impairment(s), you need and use to enable you to work. The costs are deductible even though you also need or use the items and services to carry out daily living functions unrelated to your work. Paragraph (b) of this section explains the conditions for deducting work expenses. Paragraph (c) of this section describes the expenses we will deduct. Paragraph (d) of this section explains when expenses may be deducted. Paragraph (e) of this section describes how expenses may be allocated. Paragraph (f) of this section explains the limitations on deducting expenses. Paragraph (g) of this section explains our verification procedures.

(b) *Conditions for deducting impairment-related work expenses.* We will deduct impairment-related work expenses if—

(1) You are otherwise disabled as defined in §§404.1505, 404.1577 and 404.1581–404.1583;

(2) The severity of your impairment(s) requires you to purchase (or rent) certain items and services in order to work;

(3) You pay the cost of the item or service. No deduction will be allowed to the extent that payment has been or will be made by another source. No deduction will be allowed to the extent that you have been, could be, or will be reimbursed for such cost by any other source (such as through a private insurance plan, Medicare or Medicaid, or other plan or agency). For example, if you purchase crutches for $80 but you were, could be, or will be reimbursed $64 by some agency, plan, or program, we will deduct only $16;

(4) You pay for the item or service in a month you are working (in accordance with paragraph (d) of this section); and

(5) Your payment is in cash (including checks or other forms of money). Payment in kind is not deductible.

(c) *What expenses may be deducted*—(1) *Payments for attendant care services.* (i) If because of your impairment(s) you need assistance in traveling to and from work, or while at work you need assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating), the payments you make for those services may be deducted.

(ii) If because of your impairment(s) you need assistance with personal functions (e.g., dressing, administering medications) at home in preparation for going to and assistance in returning from work, the payments you make for those services may be deducted.

(iii)(A) We will deduct payments you make to a family member for attendant care services only if such person, in order to perform the services, suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked.

(B) We consider a family member to be anyone who is related to you by blood, marriage or adoption, whether or not that person lives with you.

(iv) If only part of your payment to a person is for services that come under the provisions of paragraph (c)(1) of

this section, we will only deduct that part of the payment which is attributable to those services. For example, an attendant gets you ready for work and helps you in returning from work, which takes about 2 hours a day. The rest of his or her 8 hour day is spent cleaning your house and doing your laundry, etc. We would only deduct one-fourth of the attendant's daily wages as an impairment-related work expense.

(2) *Payments for medical devices.* If your impairment(s) requires that you utilize medical devices in order to work, the payments you make for those devices may be deducted. As used in this subparagraph, medical devices include durable medical equipment which can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers.

(3) *Payments for prosthetic devices.* If your impairment(s) requires that you utilize a prosthetic device in order to work, the payments you make for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs and other parts of the body.

(4) *Payments for equipment.* (i) *Work-related equipment.* If your impairment(s) requires that you utilize special equipment in order to do your job, the payments you make for that equipment may be deducted. Examples of work-related equipment are one-hand typewriters, vision aids, sensory aids for the blind, telecommunication devices for the deaf and tools specifically designed to accommodate a person's impairment(s).

(ii) *Residential modifications.* If your impairment(s) requires that you make modifications to your residence, the location of your place of work will determine if the cost of these modifications will be deducted. If you are employed away from home, only the cost of changes made outside of your home to permit you to get to your means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of your home will not be deducted. If you work at home, the costs of modifying the inside of your home in order to create a working space to accommodate your impairment(s) will be deducted to the extent that the changes pertain specifically to the space in which you work. Examples of such changes are the enlargement of a doorway leading into the workspace or modification of the workspace to accommodate problems in dexterity. However, if you are self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(iii) *Nonmedical appliances and equipment.* Expenses for appliances and equipment which you do not ordinarily use for medical purposes are generally not deductible. Examples of these items are portable room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners. However, expenses for such items may be deductible when unusual circumstances clearly establish an impairment-related and medically verified need for such an item because it is essential for the control of your disabling condition, thus enabling you to work. To be considered essential, the item must be of such a nature that if it were not available to you there would be an immediate adverse impact on your ability to function in your work activity. In this situation, the expense is deductible whether the item is used at home or in the working place. An example would be the need for an electric air cleaner by an individual with severe respiratory disease who cannot function in a non-purified air environment. An item such as an exercycle is not deductible if used for general physical fitness. If it is prescribed and used as necessary treatment of your impairment and necessary to enable you to work, we will deduct payments you make toward its cost.

(5) *Payments for drugs and medical services.* (i) If you must use drugs or medical services (including diagnostic

procedures) to control your impairment(s) the payments you make for them may be deducted. The drugs or services must be prescribed (or utilized) to reduce or eliminate symptoms of your impairment(s) or to slow down its progression. The diagnostic procedures must be performed to ascertain how the impairment(s) is progressing or to determine what type of treatment should be provided for the impairment(s).

(ii) Examples of deductible drugs and medical services are anticonvulsant drugs to control epilepsy or anticonvulsant blood level monitoring; antidepressant medication for mental disorders; medication used to allay the side effects of certain treatments; radiation treatment or chemotherapy for cancer patients; corrective surgery for spinal disorders; electroencephalograms and brain scans related to a disabling epileptic condition; tests to determine the efficacy of medication on a diabetic condition; and immunosuppressive medications that kidney transplant patients regularly take to protect against graft rejection.

(iii) We will only deduct the costs of drugs or services that are directly related to your impairment(s). Examples of non-deductible items are routine annual physical examinations, optician services (unrelated to a disabling visual impairment) and dental examinations.

(6) *Payments for similar items and services*—(i) *General.* If you are required to utilize items and services not specified in paragraphs (c) (1) through (5) of this section but which are directly related to your impairment(s) and which you need to work, their costs are deductible. Examples of such items and services are medical supplies and services not discussed above, the purchase and maintenance of a dog guide which you need to work, and transportation.

(ii) *Medical supplies and services not described above.* We will deduct payments you make for expendable medical supplies, such as incontinence pads, catheters, bandages, elastic stockings, face masks, irrigating kits, and disposable sheets and bags. We will also deduct payments you make for physical therapy which you require because of your impairment(s) and which you need in order to work.

(iii) *Payments for transportation costs.* We will deduct transportation costs in these situations:

(A) Your impairment(s) requires that in order to get to work you need a vehicle that has structural or operational modifications. The modifications must be critical to your operation or use of the vehicle and directly related to your impairment(s). We will deduct the costs of the modifications, but not the cost of the vehicle. We will also deduct a mileage allowance for the trip to and from work. The allowance will be based on data compiled by the Federal Highway Administration relating to vehicle operating costs.

(B) Your impairment(s) requires you to use driver assistance, taxicabs or other hired vehicles in order to work. We will deduct amounts paid to the driver and, if your own vehicle is used, we will also deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(C) Your impairment(s) prevents your taking available public transportation to and from work and you must drive your (unmodified) vehicle to work. If we can verify through your physician or other sources that the need to drive is caused by your impairment(s) (and not due to the unavailability of public transportation), we will deduct a mileage allowance, as provided in paragraph (c)(6)(iii)(A) of this section, for the trip to and from work.

(7) *Payments for installing, maintaining, and repairing deductible items.* If the device, equipment, appliance, etc., that you utilize qualifies as a deductible item as described in paragraphs (c) (2), (3), (4) and (6) of this section, the costs directly related to installing, maintaining and repairing these items are also deductible. (The costs which are associated with modifications to a vehicle are deductible. Except for a mileage allowance, as provided for in paragraph (c)(6)(iii) of this section, the costs which are associated with the vehicle itself are not deductible.)

(d) *When expenses may be deducted.* (1) *Effective date.* To be deductible an expense must be incurred after November 30, 1980. An expense may be considered

incurred after that date if it is paid thereafter even though pursuant to a contract or other arrangement entered into before December 1, 1980.

(2) *Payments for services.* A payment you make for services may be deducted if the services are received while you are working and the payment is made in a month you are working. We consider you to be working even though you must leave work temporarily to receive the services.

(3) *Payments for items.* A payment you make toward the cost of a deductible item (regardless of when it is acquired) may be deducted if payment is made in a month you are working. See paragraph (e)(4) of this section when purchases are made in anticipation of work.

(e) *How expenses are allocated.* (1) *Recurring expenses.* You may pay for services on a regular periodic basis, or you may purchase an item on credit and pay for it in regular periodic installments or you may rent an item. If so, each payment you make for the services and each payment you make toward the purchase or rental (including interest) is deductible in the month it is made.

Example: B starts work in October 1981 at which time she purchases a medical device at a cost of $4,800 plus interest charges of $720. Her monthly payments begin in October. She earns and receives $400 a month. The term of the installment contract is 48 months. No downpayment is made. The monthly allowable deduction for the item would be $115 ($5520 divided by 48) for each month of work during the 48 months.

(2) *Nonrecurring expenses.* Part or all of your expenses may not be recurring. For example, you may make a one-time payment in full for an item or service or make a downpayment. If you are working when you make the payment we will either deduct the entire amount in the month you pay it or allocate the amount over a 12 consecutive month period beginning with the month of payment, whichever you select.

Example: A begins working in October 1981 and earns $525 a month. In the same month he purchases and pays for a deductible item at a cost of $250. In this situation we could allow a $250 deduction for October 1981, reducing A's earnings below the SGA level for that month.

If A's earnings had been $15 above the SGA earnings amount, A probably would select the option of projecting the $250 payment over the 12-month period, October 1981–September 1982, giving A an allowable deduction of $20.83 a month for each month of work during that period. This deduction would reduce A's earnings below the SGA level for 12 months.

(3) *Allocating downpayments.* If you make a downpayment we will, if you choose, make a separate calculation for the downpayment in order to provide for uniform monthly deductions. In these situations we will determine the total payment that you will make over a 12 consecutive month period beginning with the month of the downpayment and allocate that amount over the 12 months. Beginning with the 13th month, the regular monthly payment will be deductible. This allocation process will be for a shorter period if your regular monthly payments will extend over a period of less than 12 months.

Example 1. C starts working in October 1981, at which time he purchases special equipment at a cost of $4,800, paying $1,200 down. The balance of $3,600, plus interest of $540, is to be repaid in 36 installments of $115 a month beginning November 1981. C earns $500 a month. He chooses to have the downpayment allocated. In this situation we would allow a deduction of $205.42 a month for each month of work during the period October 1981 through September 1982. After September 1982, the deduction amount would be the regular monthly payment of $115 for each month of work during the remaining installment period.

Explanation:

Downpayment in 10/81	$1,200	
Monthly payments 11/81 through 09/82	1,265	
	12) 2,465	=$205.42

Example 2. D, while working, buys a deductible item in July 1981, paying $1,450 down. However, his first monthly payment of $125 is not due until September 1981. D chooses to have the downpayment allocated. In this situation we would allow a deduction of $225 a month for each month of work during the period July 1981 through June 1982. After June 1982, the deduction amount would be the regular monthly payment of $125 for each month of work.

Explanation:

Downpayment in 07/81	$1,450	
Monthly payments 09/81 through 06/82	1,250	
	12) 2,700	=$225

(4) *Payments made in anticipation of work.* A payment toward the cost of a deductible item that you made in any of the 11 months preceding the month you started working will be taken into account in determining your impairment-related work expenses. When an item is paid for in full during the 11 months preceding the month you started working the payment will be allocated over the 12-consecutive month period beginning with the month of the payment. However, the only portion of the payment which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for with a one-time payment of $600, the deductible amount would be $450 ($600 divided by 12, multiplied by 9). Installment payments (including a downpayment) that you made for a particular item during the 11 months preceding the month you started working will be totaled and considered to have been made in the month of your first payment for that item within this 11 month period. The sum of these payments will be allocated over the 12-consecutive month period beginning with the month of your first payment (but never earlier than 11 months before the month work began). However, the only portion of the total which may be deductible is the portion allocated to the month work begins and the following months. For example, if an item is purchased 3 months before the month work began and is paid for in 3 monthly installments of $200 each, the total payment of $600 will be considered to have been made in the month of the first payment, that is, 3 months before the month work began. The deductible amount would be $450 ($600 divided by 12, multiplied by 9). The amount, as determined by these formulas, will then be considered to have been paid in the first month of work. We will deduct either this entire amount in the first month of work or allocate it over a 12-consecutive month period beginning with the first month of work, whichever you select. In the above examples, the individual would have the choice of having the entire $450 deducted in the first month of work or of having $37.50 a month ($450 divided by 12) deducted for each month that he works over a 12-consecutive month period, beginning with the first month of work. To be deductible the payments must be for durable items such as medical devices, prostheses, work-related equipment, residential modifications, nonmedical appliances and vehicle modifications. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies and vehicle operating costs are not deductible for purposes of this paragraph.

(f) *Limits on deductions.* (1) We will deduct the actual amounts you pay towards your impairment-related work expenses unless the amounts are unreasonable. With respect to durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services, we will apply the prevailing charges under Medicare (part B of title XVIII, Health Insurance for the Aged and Disabled) to the extent that this information is readily available. Where the Medicare guides are used, we will consider the amount that you pay to be reasonable if it is no more than the prevailing charge for the same item or service under the Medicare guidelines. If the amount you actually pay is more than the prevailing charge for the same item under the Medicare guidelines, we will deduct from your earnings the amount you paid to the extent you establish that the amount is consistent with the standard or normal charge for the same or similar item or service in your community. For items and services that are not listed in the Medicare guidelines, and for items and services that are listed in the Medicare guidelines but for which such guides cannot be used because the information is not readily available, we will consider the amount you pay to be reasonable if it does not exceed the standard or normal charge for the same or similar item(s) or service(s) in your community.

(2) Impairment-related work expenses are not deducted in computing your earnings for purposes of determining whether your work was ''services'' as described in §404.1592(b).

(3) The decision as to whether you performed substantial gainful activity in a case involving impairment-related

work expenses for items or services necessary for you to work generally will be based upon your ''earnings'' and not on the value of ''services'' you rendered. (See §§ 404.1574(b)(6) (i) and (ii), and 404.1575(a)). This is not necessarily so, however, if you are in a position to control or manipulate your earnings.

(4) The amount of the expenses to be deducted must be determined in a uniform manner in both the disability insurance and SSI programs.

(5) No deduction will be allowed to the extent that any other source has paid or will pay for an item or service. No deduction will be allowed to the extent that you have been, could be, or will be, reimbursed for payments you made. (See paragraph (b)(3) of this section.)

(6) The provisions described in the foregoing paragraphs of this section are effective with respect to expenses incurred on and after December 1, 1980, although expenses incurred after November 1980 as a result of contractual or other arrangements entered into before December 1980, are deductible. For months before December 1980 we will deduct impairment-related work expenses from your earnings only to the extent they exceeded the normal work-related expenses you would have had if you did not have your impairment(s). We will not deduct expenses, however, for those things which you needed even when you were not working.

(g) *Verification.* We will verify your need for items or services for which deductions are claimed, and the amount of the charges for those items or services. You will also be asked to provide proof that you paid for the items or services.

[48 FR 21936, May 16, 1983]

WIDOWS, WIDOWERS, AND SURVIVING DIVORCED SPOUSES

§ 404.1577 Disability defined for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

For monthly benefits payable for months prior to January 1991, the law provides that to be entitled to a widow's or widower's benefit as a disabled widow, widower, or surviving divorced spouse, you must have a medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. The impairment(s) must have been of a level of severity to prevent a person from doing any gainful activity. To determine whether you were disabled, we consider only your physical or mental impairment(s). We do not consider your age, education, and work experience. We also do not consider certain felony-related and prison-related impairments, as explained in § 404.1506. (For monthly benefits payable for months after December 1990, see § 404.1505(a).)

[57 FR 30120, July 8, 1992]

§ 404.1578 How we determine disability for widows, widowers, and surviving divorced spouses for monthly benefits payable for months prior to January 1991.

(a) For monthly benefits payable for months prior to January 1991, we will find that you were disabled and pay you widow's or widower's benefits as a widow, widower, or surviving divorced spouse if—

(1) Your impairment(s) had specific clinical findings that were the same as those for any impairment in the Listing of Impairments in appendix 1 of this subpart or were medically equivalent to those for any impairment shown there;

(2) Your impairment(s) met the duration requirement.

(b) However, even if you met the requirements in paragraphs (a) (1) and (2) of this section, we will not find you disabled if you were doing substantial gainful activity.

[57 FR 30121, July 8, 1992]

§ 404.1579 How we will determine whether your disability continues or ends.

(a) *General.* (1) The rules for determining whether disability continues for widow's or widower's monthly benefits for months after December 1990 are discussed in §§ 404.1594 through 404.1598. The rules for determining whether disability continues for monthly benefits for months prior to January 1991 are discussed in paragraph (a)(2) of this

section and paragraphs (b) through (h) of this section.

(2) If you are entitled to disability benefits as a disabled widow, widower, or surviving divorced spouse, and we must decide whether your disability continued or ended for monthly benefits for months prior to January 1991, there are a number of factors we consider in deciding whether your disability continued. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not so medically improved, we must address whether one or more exceptions applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions) before we can find that you are no longer disabled, we must also show that your impairment(s), as shown by current medical evidence, is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review your claim to determine whether your disability continues.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings (see §404.1528) associated with your impairment(s).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus which was determined to equal the level of severity contemplated by Listing 1.05.C. At the time of our prior favorable decision, you had had a laminectomy. Postoperatively, a myelogram still showed evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs, or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis of a severity as described in Listing 1.02 of appendix 1 of this subpart. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remissions and exacerbations the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Determining whether medical improvement is related to your ability to work.* If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the listing section which was used in making our most recent favorable decision, we will find that the medical improvement was related to your ability to work. We make this finding because the criteria in appendix 1 of this subpart are related to ability to work because they reflect impairments which are considered severe enough to prevent a person from doing any gainful work. We must, of course, also establish that, considering all of your current impairments not just those which existed at the time of

the most recent prior favorable medical decision, your condition does not meet or equal the requirements of appendix 1 before we could find that your disability has ended. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

(3) *Determining whether your impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity.* Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases before we can find that you are no longer disabled, we must also show that your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. All current impairments will be considered, not just the impairment(s) present at the time of our most recent favorable determination. Sections 404.1525, 404.1526, and 404.1578 set out how we will decide whether your impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(4) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical or nonmedical sources. What constitutes ''evidence'' and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(5) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will determine whether the medical improvement is related to your ability to do work based on this previously existing impairment(s). The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your ability to do work.* Paragraphs (b) (1) and (2) of this section discuss what we mean by medical improvement and how we determine whether medical improvement is related to your ability to work.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. Whether medical improvement has occurred is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining whether medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the signs, symptoms and laboratory findings, we then must determine if it is related to your ability to do work, as explained in paragraph (b)(2) of this section. In determining if the medical improvement that has occurred is related to your ability to work, we will assess whether the previously existing impairments still meet or equal the level of severity contemplated by the same listing section in appendix 1 of this subpart which was used in making our most recent favorable decision. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence of the contrary, to be unable to engage in gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. Unless an objective assessment shows that the listing

requirement is no longer met or equaled based on actual changes shown by the medical evidence, the medical improvement that has occurred will not be considered to be related to your ability to work.

(3) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether your current impairment(s) is deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. (In this way, we will be able to determine that your disability continues at the earliest time without addressing the issue of reconstructing prior evidence which can be a lengthy process.) If so, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If not, we will determine whether an attempt should be made to reconstruct those portions of the file that were relevant to our most recent favorable medical decision (e.g., medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in operation, etc.; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in §404.988.

(4) *Impairment(s) subject to temporary remission.* In some cases the evidence shows that an individual's impairment is subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairment(s), including the occurrence of prior remissions, and prospects for future worsening of the impairment(s). Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(5) *Applicable listing has been revised since the most recent favorable medical decision.* When determining whether any medical improvement is related to your ability to work, we use the same listing section in appendix 1 of this subpart which was used to make our prior favorable decision. We will use the listing as it appeared at the time of the prior decision, even where the requirement(s) of the listing was subsequently changed. The current revised listing requirement will be used if we determine that you have medically improved and it is necessary to determine whether you are now considered unable to engage in gainful activity.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if your impairment(s) is no longer considered, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, before we can find you are no longer disabled, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. As part of the review process, you will be asked about any medical therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception does or does not apply.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical therapy or technology (related to your*

ability to work). Advances in medical therapy or technology are improvements in treatment or rehabilitative methods which have favorably affected the severity of your impairment(s). We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment(s). This decision will be based on new medical evidence. In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if your impairment(s) is no longer deemed, under appendix 1 of this subpart, sufficient to preclude you from engaging in gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listing changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(3) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination) demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 of this subpart was misapplied).

Example: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether your current impairment(s) meets or equals the requirements of appendix 1 of this subpart.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously granted disability benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator believes, however, that your impairment does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see §404.988) are met.

(4) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in §404.1592. We will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(§404.1511) for purposes of deciding your eligibility for a reentitlement period (§404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination

or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may stop and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended.

(2) If you are not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (3). If there has been no decrease in medical severity, there has been no medical improvement. (see step (4).)

(3) If there has been medical improvement, we must determine (in accordance with paragraph (b)(2) of this section) whether it is related to your ability to work. If medical improvement is *not* related to your ability to do work, see step (4). If medical improvement is related to your ability to do work, see step (5).

(4) If we found at step (2) that there has been no medical improvement or if we found at step (3) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement (see paragraph (d) of this section) applies, we will proceed to step (5). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(5) If medical improvement is related to your ability to work or if one of the first group of exceptions to medical improvement applies, we will determine (considering all your impairments) whether the requirements of appendix 1

of this subpart are met or equaled. If your impairment(s) meets or equals the requirements of appendix 1 of this subpart, your disability will be found to continue. If not, your disability will be found to have ended.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months—

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See §404.1592 for a discussion of the trial work period, §404.1592a for a discussion of the reentitlement period, and §404.337 for when your benefits will end.);

(4) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, as long as we expected your impairment(s) to improve (see §404.1591);

(5) The first month in which you failed to do what we asked, without good cause when the rule set out in paragraph (e)(2) of this section applies;

(6) The first month in which the question of continuing disability arose and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(7) The first month in which you failed to follow prescribed treatment without good cause, when the rule set out in paragraph (e)(4) of this section applies; or

(8) The first month you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by medical evidence.

(h) *Before we stop your benefits.* Before we determine you are no longer disabled, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

[50 FR 50126, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994]

BLINDNESS

§404.1581 Meaning of blindness as defined in the law.

We will consider you blind under the law for a period of disability and for payment of disability insurance benefits if we determine that you are statutorily blind. Statutory blindness is defined in the law as central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less. Your blindness must meet the duration requirement in §404.1509. We do not consider certain felony-related and prison-related impairments, as explained in §404.1506.

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 5715, Feb. 8, 1983]

§404.1582 A period of disability based on blindness.

If we find that you are blind and you meet the insured status requirement, we may establish a period of disability for you regardless of whether you can do substantial gainful activity. A period of disability protects your earnings record under Social Security so that the time you are disabled will not count against you in determining whether you will have worked long enough to qualify for benefits and the amount of your benefits. However, you will not necessarily be entitled to receive disability insurance cash benefits

even though you are blind. If you are a blind person under age 55, you must be unable to do any substantial gainful activity in order to be paid disability insurance cash benefits.

§ 404.1583 How we determine disability for blind persons who are age 55 or older.

We will find that you are eligible for disability insurance benefits even though you are still engaging in substantial gainful activity, if—

(a) You are blind;

(b) You are age 55 or older; and

(c) You are unable to use the skills or abilities like the ones you used in any substantial gainful activity which you did regularly and for a substantial period of time. (However, you will not be paid any cash benefits for any month in which you are doing substantial gainful activity.)

§ 404.1584 Evaluation of work activity of blind people.

(a) *General.* If you are blind (as explained in § 404.1581), we will consider the earnings from the work you are doing to determine whether or not you should be paid cash benefits.

(b) *Under Age 55.* If you are under age 55, we will evaluate the work you are doing using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you are not doing substantial gainful activity, we will pay you cash benefits. If you are doing substantial gainful activity, we will not pay you cash benefits. However, you will be given a period of disability as described in subpart D of this part.

(c) *Age 55 or older.* If you are age 55 or older, we will evaluate your work using the guides in paragraph (d) of this section to determine whether or not your work shows that you are doing substantial gainful activity. If you have not shown this ability, we will pay you cash benefits. If you have shown an ability to do substantial gainful activity, we will evaluate your work activity to find out how your work compares with the work you did before. If the skills and abilities of your new work are about the same as those you used in the work you did before, we will not pay you cash benefits. However, if your new work requires skills and abilities which are less than or different than those you used in the work you did before, we will pay you cash benefits, but not for any month in which you actually perform substantial gainful activity.

(d) *Evaluation of earnings.* The law provides a different earnings test for substantial gainful activity of people who are blind. We will not consider that you are able to engage in substantial gainful activity on the basis of earnings unless your monthly earnings average more than $334.00 in 1978; $375.00 in 1979; $417.00 in 1980; $459.00 in 1981; and $500.00 in 1982. (Sections 404.1574(a)(2), 404.1575(c) and 404.1576 are applicable in determining the amount of your earnings.) Thereafter, an increase in the substantial gainful activity amount will depend on increases in the cost of living. For work activity performed in taxable years before 1978, the earnings considered enough to show an ability to do substantial gainful activity are the same for blind people as for others.

[45 FR 55584, Aug. 20, 1980, as amended at 48 FR 21939, May 16, 1983]

§ 404.1585 Trial work period for persons age 55 or older who are blind.

If you become eligible for disability benefits even though you were doing substantial gainful activity because you are blind and age 55 or older, you are entitled to a trial work period if—

(a) You later return to substantial gainful activity that requires skills or abilities comparable to those required in the work you regularly did before you became blind or became 55 years old, whichever is later; or

(b) Your last previous work ended because of an impairment and the current work requires a significant vocational adjustment.

§ 404.1586 Why and when we will stop your cash benefits.

(a) *When you are not entitled to benefits.* If you become entitled to disability cash benefits as a statutorily blind person, we will find that you are no longer entitled to benefits beginning with the earliest of—

(1) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in §404.1594 and you were disabled only for a specified period of time in the past;

(2) The month your vision, based on current medical evidence, does not meet the definition of blindness and your disability does not continue under the rules in §404.1594, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) If you are under age 55, the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See §404.1592a for a discussion of the reentitlement period, and §404.316 on when your benefits will end.); or

(4) If you are age 55 or older, the month (following completion of a trial work period) when your work activity shows you are able to use, in substantial gainful activity, skills and abilities comparable to those of some gainful activity which you did with some regularity and over a substantial period of time. The skills and abilities are compared to the activity you did prior to age 55 or prior to becoming blind, whichever is later.

(b) *If we find that you are not entitled to disability cash benefits.* If we find that you are not entitled to disability cash benefits on the basis of your work activity but your visual impairment is sufficiently severe to meet the definition of blindness, the period of disability that we established for you will continue.

(c) *If you do not follow prescribed treatment.* If treatment has been prescribed for you that can restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have a good reason for failing to follow that treatment (see §404.1530(c)), we will find that your disability has ended. The month in which your disability will be found to have ended will be the first month in which you failed to follow the prescribed treatment.

(d) *If you do not cooperate with us.* If we ask you to give us medical or other evidence or to go for a medical examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, §404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability will be found to have ended will be the month in which you failed to do what we asked.

(e) *If we are unable to find you.* If there is a question about whether you continue to be disabled by blindness and we are unable to find you to resolve the question, we will find that your disability, has ended. The month it ends will be the first month in which the question arose and we could not find you.

(f) *Before we stop your benefits.* Before we stop your benefits or period of disability, we will give you a chance to give us your reasons why we should not stop your benefits or your period of disability. Section 404.1595 describes your rights and the procedures we will follow.

(g) *If you are in an appropriate vocational rehabilitation program.* (1) Your benefits, and those of your dependents, may be continued for months after November 1980 after your impairment is no longer disabling if—

(i) Your disability did not end before December 1980;

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

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

(iv) We have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will

not have to return to the disability benefit rolls.

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

(i) You complete the program;

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

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

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

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 49 FR 22272, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 51 FR 17617, May 14, 1986; 59 FR 1635, Jan. 12, 1994]

§ 404.1587 Circumstances under which we may suspend your benefits before we make a determination.

We will suspend your benefits if all of the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when you are blind as defined in the law and age 55 or older and you have returned to work similar to work you previously performed.

CONTINUING OR STOPPING DISABILITY

§ 404.1588 Your responsibility to tell us of events that may change your disability status.

If you are entitled to cash benefits or to a period of disability because you are disabled, you should promptly tell us if—

(a) Your condition improves;

(b) You return to work;

(c) You increase the amount of your work; or

(d) Your earnings increase.

§ 404.1589 We may conduct a review to find out whether you continue to be disabled.

After we find that you are disabled, we must evaluate your impairment(s) from time to time to determine if you are still eligible for disability cash benefits. We call this evaluation a continuing disability review. We may begin a continuing disability review for any number of reasons including your failure to follow the provisions of the Social Security Act or these regulations. When we begin such a review, we will notify you that we are reviewing your eligibility for disability benefits, why we are reviewing your eligibility, that in medical reviews the medical improvement review standard will apply, that our review could result in the termination of your benefits, and that you have the right to submit medical and other evidence for our consideration during the continuing disability review. In doing a medical review, we will develop a complete medical history of at least the preceding 12 months in any case in which a determination is made that you are no longer under a disability. If this review shows that we should stop payment of your benefits, we will notify you in writing and give you an opportunity to appeal. In § 404.1590 we describe those events that may prompt us to review whether you continue to be disabled.

[51 FR 16825, May 7, 1986]

§ 404.1590 When and how often we will conduct a continuing disability review.

(a) *General.* We conduct continuing disability reviews to determine whether or not you continue to meet the disability requirements of the law. Payment of cash benefits or a period of disability ends if the medical or other evidence shows that you are not disabled as determined under the standards set out in section 223(f) of the Social Security Act.

(b) *When we will conduct a continuing disability review.* A continuing disability review will be started if—

(1) You have been scheduled for a medical improvement expected diary review;

(2) You have been scheduled for a periodic review (medical improvement possible or medical improvement not expected) in accordance with the provisions of paragraph (d) of this section;

(3) We need a current medical or other report to see if your disability continues. (This could happen when, for example, an advance in medical

technology, such as improved treatment for Alzheimer's disease or a change in vocational therapy or technology raises a disability issue.);

(4) You return to work and successfully complete a period of trial work;

(5) Substantial earnings are reported to your wage record;

(6) You tell us that you have recovered from your disability or that you have returned to work;

(7) Your State Vocational Rehabilitation Agency tells us that—

(i)t The services have been completed; or

(ii) You are now working; or

(iii) You are able to work;

(8) Someone in a position to know of your physical or mental condition tells us that you are not disabled, that you are not following prescribed treatment, that you have returned to work, or that you are failing to follow the provisions of the Social Security Act or these regulations, and it appears that the report could be substantially correct;

(9) Evidence we receive raises a question as to whether your disability continues; or

(10) You have been scheduled for a vocational reexamination diary review.

(c) *Definitions.* As used in this section—

Medical improvement expected diary—refers to a case which is scheduled for review at a later date because the individual's impairment(s) is expected to improve. Generally, the diary period is set for not less than 6 months or for not more than 18 months. Examples of cases likely to be scheduled for medical improvement expected diary are fractures and cases in which corrective surgery is planned and recovery can be anticipated.

Permanent impairment—medical improvement not expected—refers to a case in which any medical improvement in the person's impairment(s) is not expected. This means an extremely severe condition determined on the basis of our experience in administering the disability programs to be at least static, but more likely to be progressively disabling either by itself or by reason of impairment complications, and unlikely to improve so as to permit the individual to engage in substantial gainful activity. The interaction of the individual's age, impairment consequences and lack of recent attachment to the labor market may also be considered in determining whether an impairment is permanent. Improvement which is considered temporary under §404.1579(c)(4) or §404.1594(c)(3)(iv), as appropriate, will not be considered in deciding if an impairment is permanent. Examples of permanent impairments taken from the list contained in our other written guidelines which are available for public review are as follows and are not intended to be all inclusive:

(1) Parkinsonian Syndrome which has reached the level of severity necessary to meet the Listing in appendix 1.

(2) Amyotrophic Lateral Sclerosis which has reached the level of severity necessary to meet the Listing in appendix 1.

(3) Diffuse pulmonary fibrosis in an individual age 55 or over which has reached the level of severity necessary to meet the Listing in appendix 1.

(4) Amputation of leg at hip.

Nonpermanent impairment—refers to a case in which any medical improvement in the person's impairment(s) is possible. This means an impairment for which improvement cannot be predicted based on current experience and the facts of the particular case but which is not at the level of severity of an impairment that is considered permanent. Examples of nonpermanent impairments are: regional enteritis, hyperthyroidism, and chronic ulcerative colitis.

Vocational reexamination diary—refers to a case which is scheduled for review at a later date because the individual is undergoing vocational therapy, training or an educational program which may improve his or her ability to work so that the disability requirement of the law is no longer met. Generally, the diary period will be set for the length of the training, therapy, or program of education.

(d) *Frequency of review.* If your impairment is expected to improve, generally we will review your continuing eligibility for disability benefits at intervals from 6 months to 18

months following our most recent decision. Our notice to you about the review of your case will tell you more precisely when the review will be conducted. If your disability is not considered permanent but is such that any medical improvement in your impairment(s) cannot be accurately predicted, we will review your continuing eligibility for disability benefits at least once every 3 years. If your disability is considered permanent, we will review your continuing eligibility for benefits no less frequently than once every 7 years but no more frequently than once every 5 years. Regardless of your classification, we will conduct an immediate continuing disability review if a question of continuing disability is raised pursuant to paragraph (b) of this section.

(e) *Change in classification of impairment.* If the evidence developed during a continuing disability review demonstrates that your impairment has improved, is expected to improve, or has worsened since the last review, we may reclassify your impairment to reflect this change in severity. A change in the classification of your impairment will change the frequency with which we will review your case. We may also reclassify certain impairments because of improved tests, treatment, and other technical advances concerning those impairments.

(f) *Review after administrative appeal.* If you were found eligible to receive or to continue to receive disability benefits on the basis of a decision by an administrative law judge, the Appeals Council or a Federal court, we will not conduct a continuing disability review earlier than 3 years after that decision unless your case should be scheduled for a medical improvement expected or vocational reexamination diary review or a question of continuing disability is raised pursuant to paragraph (b) of this section.

(g) *Waiver of timeframes.* All cases involving a nonpermanent impairment will be reviewed by us at least once every 3 years unless we, after consultation with the State agency, determine that the requirement should be waived to ensure that only the appropriate number of cases are reviewed. The appropriate number of cases to be reviewed is to be based on such considerations as the backlog of pending reviews, the projected number of new applications, and projected staffing levels. Such waiver shall be given only after good faith effort on the part of the State to meet staffing requirements and to process the reviews on a timely basis. Availability of independent medical resources may also be a factor. A *waiver* in this context refers to our administrative discretion to determine the appropriate number of cases to be reviewed on a State by State basis. Therefore, your continuing disability review may be delayed longer than 3 years following our original decision or other review under certain circumstances. Such a delay would be based on our need to ensure that backlogs, reviews required to be performed by the Social Security Disability Benefits Reform Act of 1984 (Pub. L. 98–460), and new disability claims workloads are accomplished within available medical and other resources in the State agency and that such reviews are done carefully and accurately.

[51 FR 16825, May 7, 1986]

§ 404.1591 If your medical recovery was expected and you returned to work.

If your impairment was expected to improve and you returned to full-time work with no significant medical limitations and acknowledge that medical improvement has occurred, we may find that your disability ended in the month you returned to work. Unless there is evidence showing that your disability has not ended, we will use the medical and other evidence already in your file and the fact that you returned to full-time work without significant limitations to determine that you are no longer disabled. (If your impairment is not expected to improve, we will not ordinarily review your claim until the end of the trial work period, as described in § 404.1592.)

Example: Evidence obtained during the processing of your claim showed that you had an impairment that was expected to improve about 18 months after your disability began. We, therefore, told you that your claim would be reviewed again at that time. However, before the time arrived for your

scheduled medical re-examination, you told us that you had returned to work and your impairment had improved. We investigated immediately and found that, in the 16th month after your disability began, you returned to full-time work without any significant medical restrictions. Therefore, we would find that your disability ended in the first month you returned to full-time work.

[50 FR 50130, Dec. 6, 1985]

§404.1592 The trial work period.

(a) *Definition of the trial work period.* The trial work period is a period during which you may test your ability to work and still be considered disabled. It begins and ends as described in paragraph (e) of this section. During this period, you may perform *services* (see paragraph (b) of this section) in as many as 9 months, but these months do not have to be consecutive. We will not consider those services as showing that your disability has ended until you have performed services in at least 9 months. However, after the trial work period has ended we will consider the work you did during the trial work period in determining whether your disability ended at any time after the trial work period.

(b) *What we mean by services.* When used in this section, *services* means any activity, even though it is not substantial gainful activity, which is done by a person in employment or self-employment for pay or profit, or is the kind normally done for pay or profit. If you are an employee, we will consider your work to be *services* if in any calendar year after 1989 you earn more than $200 a month ($75 a month is the amount for calendar years 1979 through 1989, and $50 a month is the amount for calendar years before 1979). If you are self-employed, we will consider your activities *services* if in any calendar year after 1989, your net earnings are more than $200 a month ($75 a month is the amount for calendar years 1979 through 1989, and $50 a month is the amount for calendar years before 1979), or you work more than 40 hours a month in the business in any calendar year after 1989 (15 hours a month is the figure for calendar years before 1990). We generally do not consider work to be *services* when it is done without remuneration or merely as therapy or training, or when it is work usually done in a daily routine around the house, or in self-care.

(c) *Limitations on the number of trial work periods.* You may have only one trial work period during a period of entitlement to cash benefits.

(d) *Who is and is not entitled to a trial work period.* (1) Those who are receiving disability insurance benefits, child's benefits based on disability and, beginning December 1, 1980, those who are receiving widows' or widowers' benefits based on disability, or surviving divorced spouses' benefits based on disability, generally are entitled to a trial work period.

(2) You are not entitled to a trial work period if—

(i) You are entitled to a period of disability but not to disability insurance cash benefits; or

(ii) You are receiving disability insurance benefits in a second period of disability for which you did not have to complete a waiting period.

(e) *When the trial work period begins and ends.* The trial work period begins with the month in which you become entitled to disability insurance cash benefits, to child's cash benefits based on disability or to widow's, widower's, or surviving divorced spouse's cash benefits based on disability. It cannot begin before the month in which you file your application for benefits and for widows, widowers, and surviving divorced spouses, it cannot begin before December 1, 1980. It ends with the close of whichever of the following calendar months is the earlier:

(1) The 9th month (whether or not the months have been consecutive) in which you have performed services; or

(2) The month in which new evidence, other than evidence relating to any work you did during the trial work period, shows that you are not disabled, even though you have not worked a full 9 months. We may find that your disability has ended at any time during the trial work period if the medical or other evidence shows that you are no longer disabled (see §404.1594).

[45 FR 55584, Aug. 20, 1980, as amended at 49 FR 22273, May 29, 1984; 50 FR 50130, Dec. 6, 1985; 54 FR 53605, Dec. 29, 1989]

§ 404.1592a The reentitlement period.

(a) *General.* The reentitlement period is an additional period after 9 months of trial work during which you may continue to test your ability to work if you have a disabling impairment. You will not be paid benefits for any month, after the third month, in this period in which you do substantial gainful activity and you will be paid benefits for months in which you do not do substantial gainful activity. (See §§ 404.316, 404.337, 404.352 and 404.401a.) If anyone else is receiving monthly benefits based on your earnings record, that individual will not be paid benefits for any month for which you cannot be paid benefits during the reentitlement period. If your benefits are stopped because you do substantial gainful activity they may be started again without a new application and a new determination of disability if you discontinue doing substantial gainful activity during this period. In determining, for reentitlement benefit purposes, whether you do substantial gainful activity in a month, we consider only your work in or earnings for that month; we do not consider the average amount of your work or earnings over a period of months.

(b) *When the reentitlement period begins and ends.* The reentitlement period begins with the first month following completion of 9 months of trial work but cannot begin earlier than December 1, 1980. It ends with whichever is earlier—

(1) The month before the first month in which your impairment no longer exists or is not medically disabling; or

(2) The last day of the 15th month following the end of your trial work period. (See §§ 404.316, 404.337, and 404.352 for when your benefits end.)

(c) *When you are not entitled to a reentitlement period.* You are not entitled to a reentitlement period if:

(1) You are entitled to a period of disability, but not to disability insurance cash benefits;

(2) You are not entitled to a trial work period;

(3) Your entitlement to disability insurance benefits ended before you completed 9 months of trial work in that period of disability.

[49 FR 22273, May 29, 1984, as amended at 58 FR 64883, Dec. 10, 1993]

§ 404.1593 Medical evidence in continuing disability review cases.

(a) *General.* If you are entitled to benefits or if a period of disability has been established for you because you are disabled, we will have your case file with the supporting medical evidence previously used to establish or continue your entitlement. Generally, therefore, the medical evidence we will need for a continuing disability review will be that required to make a current determination or decision as to whether you are still disabled, as defined under the medical improvement review standard. See §§ 404.1579 and 404.1594.

(b) *Obtaining evidence from your medical sources.* You must provide us with reports from your physician, psychologist, or others who have treated or evaluated you, as well as any other evidence that will help us determine if you are still disabled. See § 404.1512. You must have a good reason for not giving us this information or we may find that your disability has ended. See § 404.1594(e)(2). If we ask you, you must contact your medical sources to help us get the medical reports. We will make every reasonable effort to help you in getting medical reports when you give us permission to request them from your physician, psychologist, or other medical sources. See § 404.1512(d)(1) concerning what we mean by every reasonable effort. In some instances, such as when a source is known to be unable to provide certain tests or procedures or is known to be nonproductive or uncooperative, we may order a consultative examination while awaiting receipt of medical source evidence. Before deciding that your disability has ended, we will develop a complete medical history covering at least the 12 months preceding the date you sign a report about your continuing disability status. See § 404.1512(c).

(c) *When we will purchase a consultative examination.* A consultative examination may be purchased when we need additional evidence to determine

whether or not your disability continues. As a result, we may ask you, upon our request and reasonable notice, to undergo consultative examinations and tests to help us determine if you are still disabled. See §404.1517. We will decide whether or not to purchase a consultative examination in accordance with the standards in §§404.1519a through 404.1519b.

[56 FR 36962, Aug. 1, 1991]

§404.1594 How we will determine whether your disability continues or ends.

(a) *General.* There is a statutory requirement that, if you are entitled to disability benefits, your continued entitlement to such benefits must be reviewed periodically. If you are entitled to disability benefits as a disabled worker or as a person disabled since childhood, or, for monthly benefits payable for months after December 1990, as a disabled widow, widower, or surviving divorced spouse, there are a number of factors we consider in deciding whether your disability continues. We must determine if there has been any medical improvement in your impairment(s) and, if so, whether this medical improvement is related to your ability to work. If your impairment(s) has not medically improved we must consider whether one or more of the exceptions to medical improvement applies. If medical improvement related to your ability to work has not occurred and no exception applies, your benefits will continue. Even where medical improvement related to your ability to work has occurred or an exception applies, in most cases (see paragraph (e) of this section for exceptions), we must also show that you are currently able to engage in substantial gainful activity before we can find that you are no longer disabled.

(b) *Terms and definitions.* There are several terms and definitions which are important to know in order to understand how we review whether your disability continues.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of your impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled. A determination that there has been a decrease in medical severity must be based on changes (improvement) in the symptoms, signs and/or laboratory findings associated with your impairment(s) (see §404.1528).

Example 1: You were awarded disability benefits due to a herniated nucleus pulposus. At the time of our prior decision granting you benefits you had had a laminectomy. Postoperatively, a myelogram still shows evidence of a persistent deficit in your lumbar spine. You had pain in your back, and pain and a burning sensation in your right foot and leg. There were no muscle weakness or neurological changes and a modest decrease in motion in your back and leg. When we reviewed your claim your treating physician reported that he had seen you regularly every 2 to 3 months for the past 2 years. No further myelograms had been done, complaints of pain in the back and right leg continued especially on sitting or standing for more than a short period of time. Your doctor further reported a moderately decreased range of motion in your back and right leg, but again no muscle atrophy or neurological changes were reported. Medical improvement has *not* occurred because there has been no decrease in the severity of your back impairment as shown by changes in symptoms, signs or laboratory findings.

Example 2: You were awarded disability benefits due to rheumatoid arthritis. At the time, laboratory findings were positive for this condition. Your doctor reported persistent swelling and tenderness of your fingers and wrists and that you complained of joint pain. Current medical evidence shows that while laboratory tests are still positive for rheumatoid arthritis, your impairment has responded favorably to therapy so that for the last year your fingers and wrists have not been significantly swollen or painful. Medical improvement has occurred because there has been a decrease in the severity of your impairment as documented by the current symptoms and signs reported by your physician. Although your impairment is subject to temporary remission and exacerbations, the improvement that has occurred has been sustained long enough to permit a finding of medical improvement. We would then determine if this medical improvement is related to your ability to work.

(2) *Medical improvement not related to ability to do work.* Medical improvement is not related to your ability to work if there has been a decrease in the severity of the impairment(s) as defined in paragraph (b)(1) of this section, present at the time of the most recent favorable medical decision, but *no* increase in your functional capacity to do basic

work activities as defined in paragraph (b)(4) of this section. If there has been any medical improvement in your impairment(s), but it is not related to your ability to do work and none of the exceptions applies, your benefits will be continued.

Example: You are 65 inches tall and weighed 246 pounds at the time your disability was established. You had venous insufficiency and persistent edema in your legs. At the time, your ability to do basic work activities was affected because you were able to sit for 6 hours, but were able to stand or walk only occasionally. At the time of our continuing disability review, you had undergone a vein stripping operation. You now weigh 220 pounds and have intermittent edema. You are still able to sit for 6 hours at a time and to stand or walk only occasionally although you report less discomfort on walking. Medical improvement has occurred because there has been a decrease in the severity of the existing impairment as shown by your weight loss and the improvement in your edema. This medical improvement is not related to your ability to work, however, because your functional capacity to do basic work activities (i.e., the ability to sit, stand and walk) has not increased.

(3) *Medical improvement that is related to ability to do work.* Medical improvement is related to your ability to work if there has been a decrease in the severity, as defined in paragraph (b)(1) of this section, of the impairment(s) present at the time of the most recent favorable medical decision *and* an increase in your functional capacity to do basic work activities as discussed in paragraph (b)(4) of this section. A determination that medical improvement related to your ability to do work has occurred does not, necessarily, mean that your disability will be found to have ended unless it is also shown that you are currently able to engage in substantial gainful activity as discussed in paragraph (b)(5) of this section.

Example 1: You have a back impairment and had a laminectomy to relieve the nerve root impingement and weakness in your left leg. At the time of our prior decision, basic work activities were affected because you were able to stand less than 6 hours, and sit no more than ½ hour at a time. You had a successful fusion operation on your back about 1 year before our review of your entitlement. At the time of our review, the weakness in your leg has decreased. Your functional capacity to perform basic work activities now is unimpaired because you now have no limitation on your ability to sit, walk, or stand. Medical improvement has occurred because there has been a decrease in the severity of your impairment as demonstrated by the decreased weakness in your leg. This medical improvement is related to your ability to work because there has also been an increase in your functional capacity to perform basic work activities (or residual functional capacity) as shown by the absence of limitation on your ability to sit, walk, or stand. Whether or not your disability is found to have ended, however, will depend on our determination as to whether you can currently engage in substantial gainful activity.

Example 2: You were injured in an automobile accident receiving a compound fracture to your right femur and a fractured pelvis. When you applied for disability benefits 10 months after the accident your doctor reported that neither fracture had yet achieved solid union based on his clinical examination. X-rays supported this finding. Your doctor estimated that solid union and a subsequent return to full weight bearing would not occur for at least 3 more months. At the time of our review 6 months later, solid union had occurred and you had been returned to full weight-bearing for over a month. Your doctor reported this and the fact that your prior fractures no longer placed any limitation on your ability to walk, stand, lift, etc., and, that in fact, you could return to fulltime work if you so desired.

Medical improvement has occurred because there has been a decrease in the severity of your impairments as shown by X-ray and clinical evidence of solid union and your return to full weight-bearing. This medical improvement is related to your ability to work because you no longer meet the same listed impairment in appendix 1 of this subpart (see paragraph (c)(3)(i) of this section). In fact, you no longer have an impairment which is severe (see § 404.1521) and your disability will be found to have ended.

(4) *Functional capacity to do basic work activities.* Under the law, disability is defined, in part, as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment(s). In determining whether you are disabled under the law, we must measure, therefore, how and to what extent your impairment(s) has affected your ability to do work. We do this by looking at how your functional capacity for doing basic work activities has been affected. Basic work activities means the abilities and aptitudes necessary to do most

jobs. Included are exertional abilities such as walking, standing, pushing, pulling, reaching and carrying, and nonexertional abilities and aptitudes such as seeing, hearing, speaking, remembering, using judgment, dealing with changes and dealing with both supervisors and fellow workers. A person who has no impairment(s) would be able to do all basic work activities at normal levels; he or she would have an unlimited functional capacity to do basic work activities. Depending on its nature and severity, an impairment will result in some limitation to the functional capacity to do one or more of these basic work activities. Diabetes, for example, can result in circulatory problems which could limit the length of time a person could stand or walk and damage to his or her eyes as well, so that the person also had limited vision. What a person can still do despite an impairment, is called his or her residual functional capacity. How the residual functional capacity is assessed is discussed in more detail in §404.1545. Unless an impairment is so severe that it is deemed to prevent you from doing substantial gainful activity (see §§404.1525 and 404.1526), it is this residual functional capacity that is used to determine whether you can still do your past work or, in conjunction with your age, education and work experience, any other work.

(i) A decrease in the severity of an impairment as measured by changes (improvement) in symptoms, signs or laboratory findings can, if great enough, result in an increase in the functional capacity to do work activities. Vascular surgery (e.g., femoropopliteal bypass) may sometimes reduce the severity of the circulatory complications of diabetes so that better circulation results and the person can stand or walk for longer periods. When new evidence showing a change in signs, symptoms and laboratory findings establishes that both medical improvement has occurred and your functional capacity to perform basic work activities, or residual functional capacity, has increased, we say that medical improvement which is related to your ability to do work has occurred. A residual functional capacity assessment is also used to determine whether you can engage in substantial gainful activity and, thus, whether you continue to be disabled (see paragraph (b)(5) of this section).

(ii) Many impairment-related factors must be considered in assessing your functional capacity for basic work activities. Age is one key factor. Medical literature shows that there is a gradual decrease in organ function with age; that major losses and deficits become irreversible over time and that maximum exercise performance diminishes with age. Other changes related to sustained periods of inactivity and the aging process include muscle atrophy, degenerative joint changes, decrease in range of motion, and changes in the cardiac and respiratory systems which limit the exertional range.

(iii) Studies have also shown that the longer an individual is away from the workplace and is inactive, the more difficult it becomes to return to ongoing gainful employment. In addition, a gradual change occurs in most jobs so that after about 15 years, it is no longer realistic to expect that skills and abilities acquired in these jobs will continue to apply to the current workplace. Thus, if you are age 50 or over and have been receiving disability benefits for a considerable period of time, we will consider this factor along with your age in assessing your residual functional capacity. This will ensure that the disadvantages resulting from inactivity and the aging process during a long period of disability will be considered. In some instances where available evidence does not resolve what you can or cannot do on a sustained basis, we will provide special work evaluations or other appropriate testing.

(5) *Ability to engage in substantial gainful activity*. In most instances, we must show that you are able to engage in substantial gainful activity before your benefits are stopped. When doing this, we will consider all your current impairments not just that impairment(s) present at the time of the most recent favorable determination. If we cannot determine that you are still disabled based on medical considerations alone (as discussed in §§404.1525 and 404.1526), we will use the new symptoms, signs and laboratory findings to

make an objective assessment of your functional capacity to do basic work activities or residual functional capacity and we will consider your vocational factors. See §§ 404.1545 through 404.1569.

(6) *Evidence and basis for our decision.* Our decisions under this section will be made on a neutral basis without any initial inference as to the presence or absence of disability being drawn from the fact that you have previously been determined to be disabled. We will consider all evidence you submit, as well as all evidence we obtain from your treating physician(s) and other medical or nonmedical sources. What constitutes *evidence* and our procedures for obtaining it are set out in §§ 404.1512 through 404.1518. Our determination regarding whether your disability continues will be made on the basis of the weight of the evidence.

(7) *Point of comparison.* For purposes of determining whether medical improvement has occurred, we will compare the current medical severity of that impairment(s) which was present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled to the medical severity of that impairment(s) at that time. If medical improvement has occurred, we will compare your current functional capacity to do basic work activities (i.e., your residual functional capacity) based on this previously existing impairment(s) with your prior residual functional capacity in order to determine whether the medical improvement is related to your ability to do work. The most recent favorable medical decision is the latest decision involving a consideration of the medical evidence and the issue of whether you were disabled or continued to be disabled which became final.

(c) *Determining medical improvement and its relationship to your abilities to do work.* Paragraphs (b) (1) through (3) of this section discuss what we mean by medical improvement, medical improvement not related to your ability to work and medical improvement that is related to your ability to work. How we will arrive at the decision that medical improvement has occurred and its relationship to the ability to do work, is discussed below.

(1) *Medical improvement.* Medical improvement is any decrease in the medical severity of impairment(s) present at the time of the most recent favorable medical decision that you were disabled or continued to be disabled and is determined by a comparison of prior and current medical evidence which must show that there have been changes (improvement) in the symptoms, signs or laboratory findings associated with that impairment(s).

(2) *Determining if medical improvement is related to ability to work.* If there is a decrease in medical severity as shown by the symptoms, signs and laboratory findings, we then must determine if it is related to your ability to do work. In paragraph (b)(4) of this section, we explain the relationship between medical severity and limitation on functional capacity to do basic work activities (or residual functional capacity) and how changes in medical severity can affect your residual functional capacity. In determining whether medical improvement that has occurred is related to your ability to do work, we will assess your residual functional capacity (in accordance with paragraph (b)(4) of this section) based on the current severity of the impairment(s) which was present at your last favorable medical decision. Your new residual functional capacity will then be compared to your residual functional capacity at the time of our most recent favorable medical decision. Unless an increase in the current residual functional capacity is based on changes in the signs, symptoms, or laboratory findings, any medical improvement that has occurred will not be considered to be related to your ability to do work.

(3) Following are some additional factors and considerations which we will apply in making these determinations.

(i) *Previous impairment met or equaled listings.* If our most recent favorable decision was based on the fact that your impairment(s) at the time met or equaled the severity contemplated by the Listing of Impairments in appendix 1 of this subpart, an assessment of your residual functional capacity would not

have been made. If medical improvement has occurred and the severity of the prior impairment(s) no longer meets or equals the same listing section used to make our most recent favorable decision, we will find that the medical improvement was related to your ability to work. Appendix 1 of this subpart describes impairments which, if severe enough, affect a person's ability to work. If the appendix level of severity is met or equaled, the individual is deemed, in the absence of evidence to the contrary, to be unable to engage in substantial gainful activity. If there has been medical improvement to the degree that the requirement of the listing section is no longer met or equaled, then the medical improvement is related to your ability to work. We must, of course, also establish that you can currently engage in gainful activity before finding that your disability has ended.

(ii) *Prior residual functional capacity assessment made.* The residual functional capacity assessment used in making the most recent favorable medical decision will be compared to the residual functional capacity assessment based on current evidence in order to determine if your functional capacity for basic work activities has increased. There will be no attempt made to reassess the prior residual functional capacity.

(iii) *Prior residual functional capacity assessment should have been made, but was not.* If the most recent favorable medical decision should have contained an assessment of your residual functional capacity (i.e., your impairments did not meet or equal the level of severity contemplated by the Listing of Impairments in appendix 1 of this subpart) but does not, either because this assessment is missing from your file or because it was not done, we will reconstruct the residual functional capacity. This reconstructed residual functional capacity will accurately and objectively assess your functional capacity to do basic work activities. We will assign the maximum functional capacity consistent with an allowance.

Example: You were previously found to be disabled on the basis that ''while your impairment did not meet or equal a listing, it did prevent you from doing your past or any other work.'' The prior adjudicator did not, however, include a residual functional capacity assessment in the rationale of this decision and a review of the prior evidence does not show that such an assessment was ever made. If a decrease in medical severity, i.e., medical improvement, has occurred, the residual functional capacity based on the current level of severity of your impairment will have to be compared with your residual functional capacity based on its prior severity in order to determine if the medical improvement is related to your ability to do work. In order to make this comparison, we will review the prior evidence and make an objective assessment of your residual functional capacity at the time of our most recent favorable medical determination, based on the symptoms, signs and laboratory findings as they then existed.

(iv) *Impairment subject to temporary remission.* In some cases the evidence shows that an individual's impairments are subject to temporary remission. In assessing whether medical improvement has occurred in persons with this type of impairment, we will be careful to consider the longitudinal history of the impairments, including the occurrence of prior remission, and prospects for future worsenings. Improvement in such impairments that is only temporary will not warrant a finding of medical improvement.

(v) *Prior file cannot be located.* If the prior file cannot be located, we will first determine whether you are able to now engage in substantial gainful activity based on all your current impairments. (In this way, we will be able to determine that your disability continues at the earliest point without addressing the often lengthy process of reconstructing prior evidence.) If you cannot engage in substantial gainful activity currently, your benefits will continue unless one of the second group of exceptions applies (see paragraph (e) of this section). If you are able to engage in substantial gainful activity, we will determine whether an attempt should be made to reconstruct those portions of the missing file that were relevant to our most recent favorable medical decision (e.g., work history, medical evidence from treating sources and the results of consultative examinations). This determination will consider the potential availability of old records in light of their age, whether the source of the evidence is still in

operation; and whether reconstruction efforts will yield a complete record of the basis for the most recent favorable medical decision. If relevant parts of the prior record are not reconstructed either because it is determined not to attempt reconstruction or because such efforts fail, medical improvement cannot be found. The documentation of your current impairments will provide a basis for any future reviews. If the missing file is later found, it may serve as a basis for reopening any decision under this section in accordance with the rules in § 404.988.

(d) *First group of exceptions to medical improvement.* The law provides for certain limited situations when your disability can be found to have ended even though medical improvement has not occurred, if you can engage in substantial gainful activity. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those limited situations where, even though there has been no decrease in severity of the impairment(s), evidence shows that the person should no longer be considered disabled or never should have been considered disabled. If one of these exceptions applies, we must also show that, taking all your current impairment(s) into account, not just those that existed at the time of our most recent favorable medical decision, you are now able to engage in substantial gainful activity before your disability can be found to have ended. As part of the review process, you will be asked about any medical or vocational therapy you received or are receiving. Your answers and the evidence gathered as a result as well as all other evidence, will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that you are the beneficiary of advances in medical or vocational therapy or technology (related to your ability to work).* Advances in medical or vocational therapy or technology are improvements in treatment or rehabilitative methods which have increased your ability to do basic work activities. We will apply this exception when substantial evidence shows that you have been the beneficiary of services which reflect these advances and they have favorably affected the severity of your impairment or your ability to do basic work activities. This decision will be based on new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) In many instances, an advanced medical therapy or technology will result in a decrease in severity as shown by symptoms, signs and laboratory findings which will meet the definition of medical improvement. This exception will, therefore, see very limited application.

(2) *Substantial evidence shows that you have undergone vocational therapy (related to your ability to work).* Vocational therapy (related to your ability to work) may include, but is not limited to, additional education, training, or work experience that improves your ability to meet the vocational requirements of more jobs. This decision will be based on substantial evidence which includes new medical evidence and a new residual functional capacity assessment. (See § 404.1545.) If, at the time of our review you have not completed vocational therapy which could affect the continuance of your disability, we will review your claim upon completion of the therapy.

Example 1: You were found to be disabled because the limitations imposed on you by your impairment allowed you to only do work that was at a sedentary level of exertion. Your prior work experience was work that required a medium level of exertion. Your age and education at the time would not have qualified you for work that was below this medium level of exertion. You enrolled in and completed a specialized training course which qualifies you for a job in data processing as a computer programmer in the period since you were awarded benefits. On review of your claim, current evidence shows that there is no medical improvement and that you can still do only sedentary work. As the work of a computer programmer is sedentary in nature, you are now able to engage in substantial gainful activity when your new skills are considered.

Example 2: You were previously entitled to benefits because the medical evidence and assessment of your residual functional capacity showed you could only do light work. Your prior work was considered to be heavy in nature and your age, education and the nature of your prior work qualified you for work which was no less than medium in exertion. The current evidence and residual functional capacity show there has been no medical improvement and that you can still

do only light work. Since you were originally entitled to benefits, your vocational rehabilitation agency enrolled you in and you successfully completed a trade school course so that you are now qualified to do small appliance repair. This work is light in nature, so when your new skills are considered, you are now able to engage in substantial gainful activity even though there has been no change in your residual functional capacity.

(3) *Substantial evidence shows that based on new or improved diagnostic or evaluative techniques your impairment(s) is not as disabling as it was considered to be at the time of the most recent favorable decision.* Changing methodologies and advances in medical and other diagnostic or evaluative techniques have given, and will continue to give, rise to improved methods for measuring and documenting the effect of various impairments on the ability to do work. Where, by such new or improved methods, substantial evidence shows that your impairment(s) is not as severe as was determined at the time of our most recent favorable medical decision, such evidence may serve as a basis for finding that you are no longer disabled, if you can currently engage in substantial gainful activity. In order to be used under this exception, however, the new or improved techniques must have become generally available after the date of our most recent favorable medical decision.

(i) *How we will determine which methods are new or improved techniques and when they become generally available.* New or improved diagnostic techniques or evaluations will come to our attention by several methods. In reviewing cases, we often become aware of new techniques when their results are presented as evidence. Such techniques and evaluations are also discussed and acknowledged in medical literature by medical professional groups and other governmental entities. Through these sources, we develop listings of new techniques and when they become generally available. For example, we will consult the Health Care Financing Administration for its experience regarding when a technique is recognized for payment under Medicare and when they began paying for the technique.

(ii) *How you will know which methods are new or improved techniques and when they become generally available.* We will let you know which methods we consider to be new or improved techniques and when they become available through two vehicles.

(A) Some of the future changes in the Listing of Impairments in appendix 1 of this subpart will be based on new or improved diagnostic or evaluative techniques. Such listings changes will clearly state this fact as they are published as Notices of Proposed Rulemaking and the new or improved technique will be considered generally available as of the date of the final publication of that particular listing in the FEDERAL REGISTER.

(B) A cumulative list since 1970 of new or improved diagnostic techniques or evaluations, how they changed the evaluation of the applicable impairment and the month and year they became generally available, will be published in the *Notices* section of the FEDERAL REGISTER. Included will be any changes in the Listing of Impairments published in the Code of Federal Regulations since 1970 which are reflective of new or improved techniques. No cases will be processed under this exception until this cumulative listing is so published. Subsequent changes to the list will be published periodically. The period will be determined by the volume of changes needed.

Example: The electrocardiographic exercise test has replaced the Master's 2-step test as a measurement of heart function since the time of your last favorable medical decision. Current evidence could show that your condition, which was previously evaluated based on the Master's 2-step test, is not now as disabling as was previously thought. If, taking all your current impairments into account, you are now able to engage in substantial gainful activity, this exception would be used to find that you are no longer disabled even if medical improvement has not occurred.

(4) *Substantial evidence demonstrates that any prior disability decision was in error.* We will apply the exception to medical improvement based on error if substantial evidence (which may be evidence on the record at the time any prior determination of the entitlement to benefits based on disability was made, or newly obtained evidence which relates to that determination)

demonstrates that a prior determination was in error. A prior determination will be found in error only if:

(i) Substantial evidence shows on its face that the decision in question should not have been made (e.g., the evidence in your file such as pulmonary function study values was misread or an adjudicative standard such as a listing in appendix 1 or a medical/vocational rule in appendix 2 of this subpart was misapplied).

Example 1: You were granted benefits when it was determined that your epilepsy met Listing 11.02. This listing calls for a finding of major motor seizures more frequently than once a month as documented by EEG evidence and by a detailed description of a typical seizure pattern. A history of either diurnal episodes or nocturnal episodes with residuals interfering with daily activities is also required. On review, it is found that a history of the frequency of your seizures showed that they occurred only once or twice a year. The prior decision would be found to be in error, and whether you were still considered to be disabled would be based on whether you could currently engage in substantial gainful activity.

Example 2: Your prior award of benefits was based on vocational rule 201.12 in appendix 2 of this subpart. This rule applies to a person age 50–54 who has at least a high school education, whose previous work was entirely at a semiskilled level, and who can do only sedentary work. On review, it is found that at the time of the prior determination you were actually only age 46 and vocational rule 201.21 should have been used. This rule would have called for a denial of your claim and the prior decision is found to have been in error. Continuation of your disability would depend on a finding of your current ability to engage in substantial gainful activity.

(ii) At the time of the prior evaluation, required and material evidence of the severity of your impairment(s) was missing. That evidence becomes available upon review, and substantial evidence demonstrates that had such evidence been present at the time of the prior determination, disability would not have been found.

Example: You were found disabled on the basis of chronic obstructive pulmonary disease. The severity of your impairment was documented primarily by pulmonary function testing results. The evidence showed that you could do only light work. Spirometric tracings of this testing, although required, were not obtained, however. On review, the original report is resubmitted by the consultative examining physician along with the corresponding spirometric tracings. A review of the tracings shows that the test was invalid. Current pulmonary function testing supported by spirometric tracings reveals that your impairment does not limit your ability to perform basic work activities in any way. Error is found based on the fact that required, material evidence which was originally missing now becomes available and shows that if it had been available at the time of the prior determination, disability would not have been found.

(iii) Substantial evidence which is new evidence which relates to the prior determination (of allowance or continuance) refutes the conclusions that were based upon the prior evidence (e.g., a tumor thought to be malignant was later shown to have actually been benign). Substantial evidence must show that had the new evidence (which relates to the prior determination) been considered at the time of the prior decision, the claim would not have been allowed or continued. A substitution of current judgment for that used in the prior favorable decision will not be the basis for applying this exception.

Example: You were previously found entitled to benefits on the basis of diabetes mellitus which the prior adjudicator believed was equivalent to the level of severity contemplated in the Listing of Impairments. The prior record shows that you had ''brittle'' diabetes for which you were taking insulin. Your urine was 3+ for sugar, and you alleged occasional hypoglycemic attacks caused by exertion. On review, symptoms, signs and laboratory findings are unchanged. The current adjudicator feels, however, that your impairment clearly does not equal the severity contemplated by the listings. Error *cannot* be found because it would represent a substitution of current judgment for that of the prior adjudicator that your impairment equaled a listing.

(iv) The exception for error will not be applied retroactively under the conditions set out above unless the conditions for reopening the prior decision (see § 404.988) are met.

(5) *You are currently engaging in substantial gainful activity.* If you are currently engaging in substantial gainful activity before we determine whether you are no longer disabled because of your work activity, we will consider whether you are entitled to a trial work period as set out in § 404.1592. We

will find that your disability has ended in the month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period, where it applies). This exception does not apply in determining whether you continue to have a disabling impairment(s) (§ 404.1511) for purposes of deciding your eligibility for a reentitlement period (§ 404.1592a).

(e) *Second group of exceptions to medical improvement.* In addition to the first group of exceptions to medical improvement, the following exceptions may result in a determination that you are no longer disabled. In these situations the decision will be made without a determination that you have medically improved or can engage in substantial gainful activity.

(1) *A prior determination or decision was fraudulently obtained.* If we find that any prior favorable determination or decision was obtained by fraud, we may find that you are not disabled. In addition, we may reopen your claim under the rules in § 404.988. In determining whether a prior favorable determination or decision was fraudulently obtained, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which you may have had at the time.

(2) *You do not cooperate with us.* If there is a question about whether you continue to be disabled and we ask you to give us medical or other evidence or to go for a physical or mental examination by a certain date, we will find that your disability has ended if you fail, without good cause, to do what we ask. Section 404.911 explains the factors we consider and how we will determine generally whether you have good cause for failure to cooperate. In addition, § 404.1518 discusses how we determine whether you have good cause for failing to attend a consultative examination. The month in which your disability ends will be the first month in which you failed to do what we asked.

(3) *We are unable to find you.* If there is a question about whether you continue to be disabled and we are unable to find you to resolve the question, we will determine that your disability has ended. The month your disability ends will be the first month in which the question arose and we could not find you.

(4) *You fail to follow prescribed treatment which would be expected to restore your ability to engage in substantial gainful activity.* If treatment has been prescribed for you which would be expected to restore your ability to work, you must follow that treatment in order to be paid benefits. If you are not following that treatment and you do not have good cause for failing to follow that treatment, we will find that your disability has ended (see § 404.1530(c)). The month your disability ends will be the first month in which you failed to follow the prescribed treatment.

(f) *Evaluation steps.* To assure that disability reviews are carried out in a uniform manner, that decisions of continuing disability can be made in the most expeditious and administratively efficient way, and that any decisions to stop disability benefits are made objectively, neutrally and are fully documented, we will follow specific steps in reviewing the question of whether your disability continues. Our review may cease and benefits may be *continued* at any point if we determine there is sufficient evidence to find that you are still unable to engage in substantial gainful activity. The steps are:

(1) Are you engaging in substantial gainful activity? If you are (and any applicable trial work period has been completed), we will find disability to have ended (see paragraph (d)(5) of this section).

(2) If you are not, do you have an impairment or combination of impairments which meets or equals the severity of an impairment listed in appendix 1 of this subpart? If you do, your disability will be found to continue.

(3) If you do not, has there been medical improvement as defined in paragraph (b)(1) of this section? If there has been medical improvement as shown by a decrease in medical severity, see step (4). If there has been no decrease in medical severity, there has been no medical improvement. (See step (5).)

(4) If there has been medical improvement, we must determine whether it is related to your ability to do work in

accordance with paragraphs (b) (1) through (4) of this section; i.e., whether or not there has been an increase in the residual functional capacity based on the impairment(s) that was present at the time of the most recent favorable medical determination. If medical improvement is *not* related to your ability to do work, see step (5). If medical improvement *is* related to your ability to do work, see step (6).

(5) If we found at step (3) that there has been no medical improvement or if we found at step (4) that the medical improvement is not related to your ability to work, we consider whether any of the exceptions in paragraphs (d) and (e) of this section apply. If none of them apply, your disability will be found to continue. If one of the first group of exceptions to medical improvement applies, see step (6). If an exception from the second group of exceptions to medical improvement applies, your disability will be found to have ended. The second group of exceptions to medical improvement may be considered at any point in this process.

(6) If medical improvement is shown to be related to your ability to do work or if one of the first group of exceptions to medical improvement applies, we will determine whether all your current impairments in combination are severe (see § 404.1521). This determination will consider all your current impairments and the impact of the combination of those impairments on your ability to function. If the residual functional capacity assessment in step (4) above shows significant limitation of your ability to do basic work activities, see step (7). When the evidence shows that all your current impairments in combination do not significantly limit your physical or mental abilities to do basic work activities, these impairments will not be considered severe in nature. If so, you will no longer be considered to be disabled.

(7) If your impairment(s) is severe, we will assess your current ability to engage in substantial gainful activity in accordance with § 404.1561. That is we will assess your residual functional capacity based on all your current impairments and consider whether you can still do work you have done in the past. If you can do such work, disability will be found to have ended.

(8) If you are not able to do work you have done in the past, we will consider one final step. Given the residual functional capacity assessment and considering your age, education and past work experience, can you do other work? If you can, disability will be found to have ended. If you cannot, disability will be found to continue.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the earliest of the following months.

(1) The month the evidence shows you are no longer disabled under the rules set out in this section, and you were disabled only for a specified period of time in the past;

(2) The month the evidence shows you are no longer disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that the information we have shows that you are not disabled;

(3) The month in which you demonstrated your ability to engage in substantial gainful activity (following completion of a trial work period); however, we may pay you benefits for certain months in and after the reentitlement period which follows the trial work period. (See § 404.1592a for a discussion of the reentitlement period. If you are receiving benefits on your own earnings record, see § 404.316 for when your benefits will end. See § 404.352 if you are receiving benefits on a parent's earnings as a disabled adult child.);

(4) The month in which you actually do substantial gainful activity (where you are not entitled to a trial work period);

(5) The month in which you return to full-time work, with no significant medical restrictions and acknowledge that medical improvement has occurred, and we expected your impairment(s) to improve (see § 404.1591);

(6) The first month in which you failed without good cause to do what we asked, when the rule set out in paragraph (e)(2) of this section applies;

(7) The first month in which the question of continuing disability arose

and we could not find you, when the rule set out in paragraph (e)(3) of this section applies;

(8) The first month in which you failed without good cause to follow prescribed treatment, when the rule set out in paragraph (e)(4) of this section applies; or

(9) The first month you were told by your physician that you could return to work provided there is no substantial conflict between your physician's and your statements regarding your awareness of your capacity for work and the earlier date is supported by the medical evidence.

(h) *Before we stop your benefits.* Before we stop your benefits or a period of disability, we will give you a chance to explain why we should not do so. Sections 404.1595 and 404.1597 describe your rights (including appeal rights) and the procedures we will follow.

[50 FR 50130, Dec. 6, 1985; 51 FR 7063, Feb. 28, 1986; 51 FR 16015, Apr. 30, 1986, as amended at 52 FR 44971, Nov. 24, 1987; 57 FR 30121, July 8, 1992; 59 FR 1635, Jan. 12, 1994]

§404.1595 When we determine that you are not now disabled.

(a) *When we will give you advance notice.* Except in those circumstances described in paragraph (d) of this section, we will give you advance notice when we have determined that you are not now disabled because the information we have conflicts with what you have told us about your disability. If your dependents are receiving benefits on your Social Security number and do not live with you, we will also give them advance notice. To give you advance notice, we will contact you by mail, telephone or in person.

(b) *What the advance notice will tell you.* We will give you a summary of the information we have. We will also tell you why we have determined that you are not now disabled, and will give you a chance to reply. If it is because of—

(1) *Medical reasons.* The advance notice will tell you what the medical information in your file shows;

(2) *Your work activity.* The advance notice will tell you what information we have about the work you are doing or have done, and why this work shows that you are not disabled; or

(3) *Your failure to give us information we need or do what we ask.* The advance notice will tell you what information we need and why we need it or what you have to do and why.

(c) *What you should do if you receive an advance notice.* If you agree with the advance notice, you do not need to take any action. If you desire further information or disagree with what we have told you, you should immediately write or telephone the State agency or the social security office that gave you the advance notice or you may visit any social security office. If you believe you are now disabled, you should tell us why. You may give us any additional or new information, including reports from your doctors, hospitals, employers or others, that you believe we should have. You should send these as soon as possible to the local social security office or to the office that gave you the advance notice. We consider 10 days to be enough time for you to tell us, although we will allow you more time if you need it. You will have to ask for additional time beyond 10 days if you need it.

(d) *When we will not give you advance notice.* We will not give you advance notice when we determine that you are not disabled if—

(1) We recently told you that the information we have shows that you are not now disabled, that we were gathering more information, and that your benefits will stop; or

(2) We are stopping your benefits because you told us you are not now disabled; or

(3) We recently told you that continuing your benefits would probably cause us to overpay you and you asked us to stop your benefits.

§404.1596 Circumstances under which we may suspend your benefits before we make a determination.

(a) *General.* Under some circumstances, we may stop your benefits before we make a determination. Generally, we do this when the information we have clearly shows you are not now disabled but we cannot determine when your disability ended. These situations are described in paragraph (b)(1) and other reasons are given in paragraph (b)(2) of this section. We refer to this as

a suspension of benefits. Your benefits, as well as those of your dependents (regardless of where they receive their benefits), may be suspended. When we do this we will give you advance notice. (See § 404.1595.) We will contact your spouse and children if they are receiving benefits on your Social Security number, and the benefits are being mailed to an address different from your own.

(b) *When we will suspend your benefits*—(1) *You are not now disabled.* We will suspend your benefits if the information we have clearly shows that you are not disabled and we will be unable to complete a determination soon enough to prevent us from paying you more monthly benefits than you are entitled to. This may occur when—

(i) New medical or other information clearly shows that you are able to do substantial gainful activity and your benefits should have stopped more than 2 months ago;

(ii) You completed a 9-month period of trial work more than 2 months ago and you are still working;

(iii) At the time you filed for benefits your condition was expected to improve and you were expected to be able to return to work. You subsequently did return to work more than 2 months ago with no significant medical restrictions; or

(iv) You are not entitled to a trial work period and you are working.

(2) *Other reasons.* We will also suspend your benefits if—

(i) You have failed to respond to our request for additional medical or other evidence and we are satisfied that you received our request and our records show that you should be able to respond.

(ii) We are unable to locate you and your checks have been returned by the Post Office as undeliverable; or

(iii) You refuse to accept vocational rehabilitation services without a good reason. Section 404.422 gives you examples of good reasons for refusing to accept vocational rehabilitation services.

(c) *When we will not suspend your cash benefits.* We will not suspend your cash benefits if—

(1) The evidence in your file does not clearly show that you are not disabled;

(2) We have asked you to furnish additional information;

(3) You have become disabled by another impairment; or

(4) After November 1980, even though your impairment is no longer disabling,

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

(ii) Your disability did not end before December 1, 1980, and

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

[45 FR 55584, Aug. 20, 1980, as amended at 47 FR 31543, July 21, 1982; 47 FR 52693, Nov. 23, 1982; 51 FR 17617, May 14, 1986]

§ 404.1597 After we make a determination that you are not now disabled.

(a) *General.* If we determine that you do not meet the disability requirements of the law, your benefits generally will stop. We will send you a formal written notice telling you why we believe you are not disabled and when your benefits should stop. If your spouse and children are receiving benefits on your Social Security number, we will also stop their benefits and tell them why. The notices will explain your right to reconsideration if you disagree with our determination. However, your benefits may continue after November 1980 even though your impairment is no longer disabling, if your disability did not end before December 1980, and you are particpating in an appropriate vocational rehabilitation program as described in § 404.1596 which you began before your disability ended. In addition, we must have determined that your completion of the program, or your continuation in the program for a specified period of time, will significantly increase the likelihood that you will not have to return to the disability benefit rolls. You may still

appeal our determination that you are not disabled even though your benefits are continuing because of your participation in an appropriate vocational rehabilitation program. You may also appeal a determination that your completion or of continuation for a specified period of time in an appropriate vocational rehabilitation program will not significantly increase the likelihood that you will not have to return to the disability benefit rolls and, therefore, you are not entitled to continue to receive benefits.

(b) *If we make a determination that your physical or mental impairment(s) has ceased, did not exist, or is no longer disabling (Medical Cessation Determination).* If we make a determination that the physical or mental impairment(s) on the basis of which benefits were payable has ceased, did not exist, or is no longer disabling (a medical cessation determination), your benefits will stop. As described in paragraph (a) of this section, you will receive a written notice explaining this determination and the month your benefits will stop. The written notice will also explain your right to appeal if you disagree with our determination and your right to request that your benefits and the benefits, if any, of your spouse or children, be continued under §404.1597a. For the purpose of this section, *benefits* means disability cash payments and/or Medicare, if applicable. The continued benefit provisions of this section do not apply to an initial determination on an application for disability benefits, or to a determination that you were disabled only for a specified period of time.

[47 FR 31544, July 21, 1982, as amended at 51 FR 17618, May 14, 1986; 53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988]

§404.1597a Continued benefits pending appeal of a medical cessation determination.

(a) *General.* If we determine that you are not entitled to benefits because the physical or mental impairment(s) on the basis of which such benefits were payable is found to have ceased, not to have existed, or to no longer be disabling, and you appeal that determination, you may choose to have your benefits continued pending reconsideration and/or a hearing before an administrative law judge on the disability cessation determination. For the purpose of this entire section, the election of *continued benefits* means the election of disability cash payments and/or Medicare, if applicable. You can also choose to have the benefits continued for anyone else receiving benefits based on your wages and self-employment income (and anyone else receiving benefits because of your entitlement to benefits based on disability). If you appeal a medical cessation under both title II and title XVI (a concurrent case), the title II claim will be handled in accordance with title II regulations while the title XVI claim will be handled in accordance with the title XVI regulations.

(b) *When the provisions of this section are available.* (1) Benefits may be continued under this section only if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling is made on or after January 12, 1983 (or before January 12, 1983, and a timely request for reconsideration or a hearing before an administrative law judge is pending on that date).

(2) Benefits may be continued under this section only for months beginning with January 1983, or the first month for which benefits are no longer otherwise payable following our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, whichever is later.

(3) Continued payment of benefits under this section will stop effective with the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law

judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or receipt of worker's compensation) which occur while you are receiving these continued benefits and affect your right to receive continued benefits.

(c) *Continuation of benefits for anyone else pending your appeal.* (1) When you file a request for reconsideration or hearing before an administrative law judge on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or your case has been sent back (remanded) to an administrative law judge for further action, you may also choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income (and for anyone else receiving benefits because of your entitlement to benefits based on disability), pending the outcome of your appeal.

(2) If anyone else is receiving benefits based on your wages and self-employment income, we will notify him or her of the right to choose to have his or her benefits continue pending the outcome of your appeal. Such benefits can be continued for the time period in paragraph (b) of this section only if he or she chooses to have benefits continued and you also choose to have his or her benefits continued.

(d) *Statement of choice.* When you or another party request reconsideration under § 404.908(a) or a hearing before an administrative law judge under § 404.932(a) on our determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, or if your case is sent back (remanded) to an administrative law judge for further action, we will explain your right to receive continued benefits and ask you to complete a statement specifying which benefits you wish to have continued pending the outcome of the reconsideration or hearing before an administrative law judge. You may elect to receive only Medicare benefits during appeal even if you do not want to receive continued disability benefits. If anyone else is receiving benefits based on your wages and self-employment income (or because of your entitlement to benefits based on disability), we will ask you to complete a statement specifying which benefits you wish to have continued for them, pending the outcome of the request for reconsideration or hearing before an administrative law judge. If you request appeal but you do not want to receive continued benefits, we will ask you to complete a statement declining continued benefits indicating that you do not want to have your benefits and those of your family, if any, continued during the appeal.

(e) *Your spouse's or children's statement of choice.* If you request, in accordance with paragraph (d) of this section, that benefits also be continued for anyone who had been receiving benefits based on your wages and self-employment, we will send them a written notice. The notice will explain their rights and ask them to complete a statement either declining continued benefits, or specifying which benefits they wish to have continued, pending the outcome of the request for reconsideration or a hearing before an administrative law judge.

(f) *What you must do to receive continued benefits pending notice of our reconsideration determination.* (1) If you want to receive continued benefits pending the outcome of your request for reconsideration, you must request reconsideration and continuation of benefits no later than 10 days after the date you receive the notice of our initial determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Reconsideration must be requested as provided in § 404.909, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you fail to request reconsideration and continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending a reconsidered determination, we will use the rules in § 404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the notice of the initial cessation determination. If you request continued benefits

after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(g) *What you must do to receive continued benefits pending an administrative law judge's decision.* (1) To receive continued benefits pending an administrative law judge's decision on our reconsideration determination, you must request a hearing and continuation of benefits no later than 10 days after the date you receive the notice of our reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. A hearing must be requested as provided in §404.933, and you must request continued benefits using a statement in accordance with paragraph (d) of this section.

(2) If you request continued benefits pending an administrative law judge's decision but did not request continued benefits while we were reconsidering the initial cessation determination, your benefits will begin effective the month of the reconsideration determination.

(3) If you fail to request continued payment of benefits within the 10-day period required by paragraph (g)(1) of this section, but you later ask that we continue your benefits pending an administrative law judge's decision on our reconsidered determination, we will use the rules as provided in §404.911 to determine whether good cause exists for your failing to request benefit continuation within 10 days after receipt of the reconsideration determination. If you request continued benefits after the 10-day period, we will consider the request to be timely and will pay continued benefits only if good cause for delay is established.

(h) *What anyone else must do to receive continued benefits pending our reconsideration determination or an administrative law judge's decision.* (1) When you or another party (see §§404.908(a) and 404.932(a)) request a reconsideration or a hearing before an administrative law judge on our medical cessation determination or when your case is sent back (remanded) to an administrative law judge for further action, you may choose to have benefits continue for anyone else who is receiving benefits based on your wages and self-employment income. An eligible individual must also choose whether or not to have his or her benefits continue pending your appeal by completing a separate statement of election as described in paragraph (e) of this section.

(2) He or she must request continuation of benefits no later than 10 days after the date he or she receives notice of termination of benefits. He or she will then receive continued benefits beginning with the later of January 1983, or the first month for which benefits are no longer otherwise payable following our initial or reconsideration determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling. Continued benefits will continue until the earlier of:

(i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of the new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or

(ii) The month before the month no timely request for a reconsideration or a hearing before an administrative law judge is pending. These continued benefits may be stopped or adjusted because of certain events (such as work and earnings or payment of worker's compensation) which occur while an eligible individual is receiving continued benefits and affect his or her right to receive continued benefits.

(3) If he or she fails to request continuation of benefits within the 10-day period required by this paragraph, but requests continuation of benefits at a later date, we will use the rules as provided in §404.911 to determine whether good cause exists for his or her failure to request continuation of benefits within 10 days after receipt of the notice of termination of his or her benefits. His or her late request will be considered to be timely and we will pay him or her continued benefits only if good cause for delay is established.

(4) If you choose not to have benefits continued for anyone else who is receiving benefits based on your wages and self-employment income, pending the appeal on our determination, we will not continue benefits to him or her.

(i) *What you must do when your case is remanded to an administrative law judge.* If we send back (remand) your case to an administrative law judge for further action under the rules provided in § 404.977, and the administrative law judge's decision or dismissal order issued on your medical cessation appeal is vacated and is no longer in effect, continued benefits are payable pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the administrative law judge's recommended decision.

(1) If you (and anyone else receiving benefits based on your wages and self-employment income or because of your disability) previously elected to receive continued benefits pending the administrative law judge's decision, we will automatically start these same continued benefits again. We will send you a notice telling you this, and that you do not have to do anything to have these same benefits continued until the month before the month the new decision of order of dismissal is issued by the administrative law judge or until the month before the month the Appeals Council takes final action on the administrative law judge's recommended decision. These benefits will begin again with the first month of nonpayment based on the prior administrative law judge hearing decision or dismissal order. Our notice explaining reinstatement of continued benefits will also tell you to report to us any changes or events that affect your receipt of benefits.

(2) After we automatically reinstate your continued benefits as described in paragraph (h)(1) of this section, we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events that affect the right to receive benefits involving you, your spouse and/or children. If you have returned to work, we will request additional information about this work activity. If you are working, your continued benefits will not be stopped while your appeal of the medical cessation of disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. In this event, we will suspend your continued benefits. If any other changes have occurred which would require a reduction in benefit amounts, or nonpayment of benefits, we will send an advance notice to advise of any adverse change before the adjustment action is taken. The notice will also advise you of the right to explain why these benefits should not be adjusted or stopped. You will also receive a written notice of our determination. The notice will also explain your right to reconsideration if you disagree with this determination.

(3) If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision.

(4) If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(5) If you (or the others receiving benefits based on your wages and self-employment income or because of your disability) did not previously elect to have benefits continued pending an administrative law judge decision, and you now want to elect continued benefits, you must request to do so no later than 10 days after you receive our notice telling you about continued benefits. If you fail to request continued benefits within the 10-day period required by paragraph (f)(1) of this section, but later ask that we continue your benefits pending an administrative law judge remand decision, we will use the rules in § 404.911 to determine whether good cause exists for your failing to request benefit continuation

within 10 days after receipt of the notice telling you about benefit continuation. We will consider the request to be timely and will pay continued benefits only if good cause for delay is established. If you make this new election, benefits may begin with the month of the order sending (remanding) your case back to the administrative law judge. Before we begin to pay you continued benefits as described in paragraph (h)(1) of this section we will contact you to determine if any adjustment is required to the amount of continued benefits payable due to events which may affect your right to benefits. If you have returned to work, we will request additional information about this work activity. If you are working, continued benefits may be started and will not be stopped because of your work while your appeal of the medical cessation of your disability is still pending unless you have completed a trial work period and are engaging in substantial gainful activity. If any changes have occurred which establish a basis for not paying continued benefits or a reduction in benefit amount, we will send you a notice explaining the adjustment or the reason why we cannot pay continued benefits. The notice will also explain your right to reconsideration if you disagree with this determination. If the final decision on your appeal of your medical cessation is a favorable one, we will send you a written notice in which we will advise you of your right to benefits, if any, before you engaged in substantial gainful activity and to reentitlement should you stop performing substantial gainful activity. If you disagree with our determination, you will have the right to appeal this decision. If the final decision on your appeal of your medical cessation is an unfavorable one (the cessation is affirmed), you will also be sent a written notice advising you of our determination, and your right to appeal if you think we are wrong.

(6) If a court orders that your case be sent back to us (remanded) and your case is sent to an administrative law judge for further action under the rules provided in §404.983, the administrative law judge's decision or dismissal order on your medical cessation appeal is vacated and is no longer in effect. Continued benefits are payable to you and anyone else receiving benefits based on your wages and self-employment income or because of your disability pending a new decision by the administrative law judge or final action is taken by the Appeals Council on the administrative law judge's recommended decision. In these court-remanded cases reaching the administrative law judge, we will follow the same rules provided in paragraphs (i) (1), (2), (3), (4) and (5) of this section.

(j) *Responsibility to pay back continued benefits.* (1) If the final decision of the Commissioner affirms the determination that you are not entitled to benefits, you will be asked to pay back any continued benefits you receive. However, as described in the overpayment recovery and waiver provisions of subpart F of this part, you will have the right to ask that you not be required to pay back the benefits. You will not be asked to pay back any Medicare benefits you received during the appeal.

(2) Anyone else receiving benefits based on your wages and self-employment income (or because of your disability) will be asked to pay back any continued benefits he or she received if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling, is not changed by the final decision of the Commissioner. However, he or she will have the right to ask that he or she not be required to pay them back, as described in the overpayment recovery and waiver provisions of subpart F of this part. He or she will not be asked to pay back any Medicare benefits he or she received during the appeal.

(3) Waiver of recovery of an overpayment resulting from the continued benefits paid to you or anyone else receiving benefits based on your wages and self-employment income (or because of your disability) may be considered as long as the determination was appealed in good faith. It will be assumed that such appeal is made in good faith and, therefore, any overpaid individual has the right to waiver consideration *unless* such individual fails to cooperate in connection with the appeal, e.g., if the individual fails (without good reason)

to give us medical or other evidence we request, or to go for a physical or mental examination when requested by us, in connection with the appeal. In determining whether an individual has good cause for failure to cooperate and, thus, whether an appeal was made in good faith, we will take into account any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) the individual may have which may have caused the individual's failure to cooperate.

[53 FR 29020, Aug. 2, 1988; 53 FR 39015, Oct. 4, 1988, as amended at 57 FR 1383, Jan. 14, 1992; 59 FR 1635, Jan. 12, 1994; 62 FR 38451, July 18, 1997; 65 FR 16814, Mar. 30, 2000]

§ 404.1598 If you become disabled by another impairment(s).

If a new severe impairment(s) begins in or before the month in which your last impairment(s) ends, we will find that your disability is continuing. The new impairment(s) need not be expected to last 12 months or to result in death, but it must be severe enough to keep you from doing substantial gainful activity, or severe enough so that you are still disabled under § 404.1594.

[50 FR 50136, Dec. 6, 1985]

§ 404.1599 Work incentive experiments and rehabilitation demonstration projects in the disability program.

(a) *Authority and purpose.* Section 505(a) of the Social Security Disability Amendments of 1980, Pub. L. 96–265, directs the Commissioner to develop and conduct experiments and demonstration projects designed to provide more cost-effective ways of encouraging disabled beneficiaries to return to work and leave benefit rolls. These experiments and demonstration projects will test the advantages and disadvantages of altering certain limitations and conditions that apply to title II disabled beneficiaries. The objective of all work incentive experiments or rehabilitation demonstrations is to determine whether the alternative requirements will save Trust Fund monies or otherwise improve the administration of the disability program established under title II of the Act.

(b) *Altering benefit requirements, limitations or conditions.* Notwithstanding any other provision of this part, the Commissioner may waive compliance with the entitlement and payment requirements for disabled beneficiaries to carry our experiments and demonstration projects in the title II disability program. The projects involve altering certain limitations and conditions that currently apply to applicants and beneficiaries to test their effect on the program.

(c) *Applicability and scope*—(1) *Participants and nonparticipants.* If you are selected to participate in an experiment or demonstration project, we may temporarily set aside one or more of the current benefit entitlement or payment requirements, limitations or conditions and apply alternative provisions to you. We may also modify current methods of administering the Act as part of a project and apply alternative procedures or policies to you. The alternative provisions or methods of administration used in the projects will not disadvantage you in contrast to current provisions, procedures or policies. If you are not selected to participate in the experiments or demonstration projects (or if you are placed in a control group which is not subject to alternative requirements and methods) we will continue to apply to you the current benefit entitlement and payment requirements, limitations and conditions and methods of administration in the title II disability program.

(2) *Alternative provisions or methods of administration.* The alternative provisions or methods of administration that apply to you in an experiment or demonstration project may include (but are not limited to) one or more of the following:

(i) Reducing your benefits (instead of not paying) on the basis of the amount of your earnings in excess of the SGA amount;

(ii) Extending your benefit eligibility period that follows 9 months of trial work, perhaps coupled with benefit reductions related to your earnings;

(iii) Extending your Medicare benefits if you are severely impaired and return to work even though you may not be entitled to monthly cash benefits;

(iv) Altering the 24-month waiting period for Medicare entitlement; and

(v) Stimulating new forms of rehabilitation.

(d) *Selection of participants.* We will select a probability sample of participants for the work incentive experiments and demonstration projects from newly awarded beneficiaries who meet certain pre-selection criteria (for example, individuals who are likely to be able to do substantial work despite continuing severe impairments). These criteria are designed to provide larger subsamples of beneficiaries who are not likely either to recover medically or die. Participants may also be selected from persons who have been receiving DI benefits for 6 months or more at the time of selection.

(e) *Duration of experiments and demonstration projects.* A notice describing each experiment or demonstration project will be published in the FEDERAL REGISTER before each experiment or project is placed in operation. The work incentive experiments and rehabilitation demonstrations will be activated in 1982. A final report on the results of the experiments and projects is to be completed and transmitted to Congress by June 9, 1993. However, the authority for the experiments and demonstration projects will not terminate at that time. Some of the alternative provisions or methods of administration may continue to apply to participants in an experiment or demonstration project beyond that date in order to assure the validity of the research. Each experiment and demonstration project will have a termination date (up to 10 years from the start of the experiment or demonstration project).

[48 FR 7575, Feb. 23, 1983, as amended at 52 FR 37605, Oct. 8, 1987; 55 FR 51687, Dec. 17, 1990; 62 FR 38451, July 18, 1997]

APPENDIX 1 TO SUBPART P OF PART 404—LISTING OF IMPAIRMENTS

The body system listings in parts A and B of the Listing of Impairments will no longer be effective on the following dates unless extended by the Commissioner or revised and promulgated again.

1. Growth Impairment (100.00): July 2, 2001.
2. Musculoskeletal System (1.00 and 101.00): July 2, 2001.
3. Special Senses and Speech (2.00 and 102.00): July 2, 2001.
4. Respiratory System (3.00 and 103.00): October 7, 2000.
5. Cardiovascular System (4.00 and 104.00): July 2, 2001.
6. Digestive System (5.00 and 105.00): July 2, 2001.
7. Genito-Urinary System (6.00 and 106.00): July 2, 2001.
8. Hemic and Lymphatic System (7.00 and 107.00): July 2, 2001.
9. Skin (8.00): July 2, 2001.
10. Endocrine System (9.00 and 109.00): July 2, 2001.
11. Multiple Body Systems (110.00): July 2, 2001.
12. Neurological (11.00 and 111.00): July 2, 2001.
13. Mental Disorders (12.00 and 112.00): July 2, 2001.
14. Neoplastic Diseases, Malignant (13.00 and 113.00): July 2, 2001.
15. Immune System (14.00 and 114.00): July 2, 2001.

Part A

Criteria applicable to individuals age 18 and over and to children under age 18 where criteria are appropriate.

Sec.
1.00 Musculoskeletal System.
2.00 Special Senses and Speech.
3.00 Respiratory System.
4.00 Cardiovascular System.
5.00 Digestive System.
6.00 Genito-Urinary System.
7.00 Hemic and Lymphatic System.
8.00 Skin.
9.00 Endocrine System.
10.00 [Reserved]
11.00 Neurological.
12.00 Mental Disorders.
13.00 Neoplastic Diseases, Malignant.
14.00 Immune System.

1.00 MUSCULOSKELETAL SYSTEM

A. *Loss of function* may be due to amputation or deformity. Pain may be an important factor in causing functional loss, but it must be associated with relevant abnormal signs or laboratory findings. Evaluations of musculoskeletal impairments should be supported where applicable by detailed descriptions of the joints, including ranges of motion, condition of the musculature, sensory or reflex changes, circulatory deficits, and X-ray abnormalities.

B. *Disorders of the spine,* associated with vertebrogenic disorders as in 1.05C, result in impairment because of distortion of the bony and ligamentous architecture of the spine or impingement of a herniated nucleus pulposus or bulging annulus on a nerve root. Impairment caused by such abnormalities usually improves with time or responds to treatment. Appropriate abnormal physical findings must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that severe

impairment will last for a continuous period of 12 months. This may occur in cases with unsuccessful prior surgical treatment.

Evaluation of the impairment caused by disorders of the spine requires that a clinical diagnosis of the entity to be evaluated first must be established on the basis of adequate history, physical examination, and roentgenograms. The specific findings stated in 1.05C represent the level required for that impairment; these findings, by themselves, are not intended to represent the basis for establishing the clinical diagnosis. Furthermore, while neurological examination findings are required, they are not to be interpreted as a basis for evaluating the magnitude of any neurological impairment. Neurological impairments are to be evaluated under 11.00–11.19.

The history must include a detailed description of the character, location, and radiation of pain; mechanical factors which incite and relieve pain; prescribed treatment, including type, dose, and frequency of analgesic; and typical daily activities. Care must be taken to ascertain that the reported examination findings are consistent with the individual's daily activities.

There must be a detailed description of the orthopedic and neurologic examination findings. The findings should include a description of gait, limitation of movement of the spine given quantitatively in degrees from the vertical position, motor and sensory abnormalities, muscle spasm, and deep tendon reflexes. Observations of the individual during the examination should be reported; e.g., how he or she gets on and off the examining table. Inability to walk on heels or toes, to squat, or to arise from a squatting position, where appropriate, may be considered evidence of significant motor loss. However, a report of atrophy is not acceptable as evidence of significant motor loss without circumferential measurements of both thighs and lower legs (or upper or lower arms) at a stated point above and below the knee or elbow given in inches or centimeters. A specific description of atrophy of hand muscles is acceptable without measurements of atrophy but should include measurements of grip strength.

These physical examination findings must be determined on the basis of objective observations during the examination and not simply a report of the individual's allegation, e.g., he says his leg is weak, numb, etc. Alternative testing methods should be used to verify the objectivity of the abnormal findings, e.g., a seated straight-leg raising test in addition to a supine straight-leg raising test. Since abnormal findings may be intermittent, their continuous presence over a period of time must be established by a record of ongoing treatment. Neurological abnormalities may not completely subside after surgical or nonsurgical treatment, or with the passage of time. Residual neurological abnormalities, which persist after it has been determined clinically or by direct surgical or other observation that the ongoing or progressive condition is no longer present, cannot be considered to satisfy the required findings in 1.05C.

Where surgical procedures have been performed, documentation should include a copy of the operative note and available pathology reports.

Electrodiagnostic procedures and myelography may be useful in establishing the clinical diagnosis, but do not constitute alternative criteria to the requirements in 1.05C.

C. *After maximum benefit from surgical therapy* has been achieved in situations involving fractures of an upper extremity (see 1.12) or soft tissue injuries of a lower or upper extremity (see 1.13), i.e., there have been no significant changes in physical findings or X-ray findings for any 6-month period after the last definitive surgical procedure, evaluation should be made on the basis of demonstrable residuals.

D. *Major joints* as used herein refer to hip, knee, ankle, shoulder, elbow, or wrist and hand. (Wrist and hand are considered together as one major joint.)

E. *The measurements of joint motion are* based on the techniques described in the ''Joint Motion Method of Measuring and Recording,'' published by the American Academy of Orthopedic Surgeons in 1965, or the ''Guides to the Evaluation of Permanent Impairment—The Extremities and Back'' (Chapter I); American Medical Association, 1971.

F. *Effects of obesity*. Obesity is a medically determinable impairment that is often associated with disturbance of the musculoskeletal system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with musculoskeletal impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

5. Listing 3.00 in part A of appendix 1 is amended by removing the last sentence of paragraph H and adding new paragraph I. to read as follows:

3.00 Respiratory System

1.01 Category of Impairments, Musculoskeletal

1.02 *Active rheumatoid arthritis and other inflammatory arthritis.*

With both A and B.

A. History of persistent joint pain, swelling, and tenderness involving multiple major joints (see 1.00D) and with signs of joint inflammation (swelling and tenderness) on current physical examination despite prescribed therapy for at least 3 months, resulting in significant restriction of function of the affected joints, and clinical activity expected to last at least 12 months; and

B. Corroboration of diagnosis at some point in time by either.

1. Positive serologic test for rheumatoid factor; or

2. Antinuclear antibodies; or

3. Elevated sedimentation rate; or

4. Characteristic histologic changes in biopsy of synovial membrane or subcutaneous nodule (obtained independent of Social Security disability evaluation).

1.03 *Arthritis of a major weight-bearing joint (due to any cause):*

With history of persistent joint pain and stiffness with signs of marked limitation of motion or abnormal motion of the affected joint on current physical examination. With:

A. Gross anatomical deformity of hip or knee (e.g, subluxation, contracture, bony or fibrous ankylosis, instability) supported by X-ray evidence of either significant joint space narrowing or significant bony destruction and markedly limiting ability to walk and stand; or

B. Reconstructive surgery or surgical arthrodesis of a major weight-bearing joint and return to full weight-bearing status did not occur, or is not expected to occur, within 12 months of onset.

1.04 *Arthritis of one major joint in each of the upper extremities (due to any cause):*

With history of persistent joint pain and stiffness, signs of marked limitation of motion of the affected joints on current physical examination, and X-ray evidence of either significant joint space narrowing or significant bony destruction. With:

A. Abduction and forward flexion (elevation) of both arms at the shoulders, including scapular motion, restricted to less than 90 degrees; or

B. Gross anatomical deformity (e.g., subluxation, contracture, bony or fibrous ankylosis, instability, ulnar deviation) and enlargement or effusion of the affected joints.

1.05 *Disorders of the spine:*

A. Arthritis manifested by ankylosis or fixation of the cervical or dorsolumbar spine at 30° or more of flexion measured from the neutral postion, with X-ray evidence of:

1. Calcification of the anterior and lateral ligaments; or

2. Bilateral ankylosis of the sacroiliac joints with abnormal apophyseal articulations; or

B. Osteoporosis, generalized (established by X-ray) manifested by pain and limitation of back motion and paravertebral muscle spasm with X-ray evidence of either:

1. Compression fracture of a vertebral body with loss of at least 50 percent of the estimated height of the vertebral body prior to the compression fracture, with no intervening direct traumatic episode; or

2. Multiple fractures of vertebrae with no intervening direct traumatic episode; or

C. Other vertebrogenic disorders (e.g., herniated nucleus puplosus, spinal stenosis) with the following persisting for at least 3 months despite prescribed therapy and expected to last 12 months. With both 1 and 2:

1. Pain, muscle spasm, and significant limitation of motion in the spine; and

2. Appropriate radicular distribution of significant motor loss with muscle weakness and sensory and reflex loss.

1.08 *Osteomyelitis or septic arthritis (established by X-ray):*

A. Located in the pelvis, vertebra, femur, tibia, or a major joint of an upper or lower extremity, with persistent activity or occurrence of at least two episodes of acute activity within a 5-month period prior to adjudication, manifested by local inflammatory, and systemic signs and laboratory findings (e.g., heat, redness, swelling, leucocytosis, or increased sedimentation rate) and expected to last at least 12 months despite prescribed therapy; or

B. Multiple localizations and systemic manifestations as in A above.

1.09 *Amputation or anatomical deformity of (i.e., loss of major function due to degenerative changes associated with vascular or neurological deficits, traumatic loss of muscle mass or tendons and X-ray evidence of bony ankylosis at an unfavorable angle, joint subluxation or instability):*

A. Both hands; or

B. Both feet; or

C. One hand and one foot.

1.10 *Amputation of one lower extremity (at or above the tarsal region):*

A. Hemipelvectomy or hip disarticulation; or

B. Amputation at or above the tarsal region due to peripheral vascular disease or diabetes mellitus; or

C. Inability to use a prosthesis effectively, without obligatory assistive devices, due to one of the following:

1. Vascular disease; or

2. Neurological complications (e.g., loss of position sense); or

3. Stump too short or stump complications persistent, or are expected to persist, for at least 12 months from onset; or

4. Disorder of contralateral lower extremity which markedly limits ability to walk and stand.

1.11 *Fracture of the femur, tibia, tarsal bone or pelvis* with solid union not evident on X-ray and not clinically solid, when such determination is feasible, and return to full

weight-bearing status did not occur or is not expected to occur within 12 months of onset.

1.12 *Fractures of an upper extremity* with non-union of a fracture of the shaft of the humerus, radius, or ulna under continuing surgical management directed toward restoration of functional use of the extremity and such function was not restored or expected to be restored within 12 months after onset.

1.13 *Soft tissue injuries of an upper or lower extremity* requiring a series of staged surgical procedures within 12 months after onset for salvage and/or restoration of major function of the extremity, and such major function was not restored or expected to be restored within 12 months after onset.

2.00 Special Senses and Speech

A. *Ophthalmology*

1. *Causes of impairment.* Diseases or injury of the eyes may produce loss of central or peripheral vision. Loss of central vision results in inability to distinguish detail and prevents reading and fine work. Loss of peripheral vision restricts the ability of an individual to move about freely. The extent of impairment of sight should be determined by visual testing.

2. *Central visual acuity.* A loss of central visual acuity may be caused by impaired distant and/or near vision. However, for an individual to meet the level of severity described in 2.02 and 2.04, only the remaining central visual acuity for distance of the better eye with best correction based on the Snellen test chart measurement may be used. Correction obtained by special visual aids (e.g., contact lenses) will be considered if the individual has the ability to wear such aids.

3. *Field of vision.* Impairment of peripheral vision may result if there is contraction of the visual fields. The contraction may be either symmetrical or irregular. The extent of the remaining peripheral visual field will be determined by usual perimetric methods at a distance of 330 mm. under illumination of not less than 7-foot candles. For the phakic eye (the eye with a lens), a 3 mm. white disc target will be used, and for the aphakic eye (the eye without the lens), a 6 mm. white disc target will be used. In neither instance should corrective spectacle lenses be worn during the examination but if they have been used, this fact must be stated.

Measurements obtained on comparable perimetric devices may be used; this does not include the use of tangent screen measurements. For measurements obtained using the Goldmann perimeter, the object size designation III and the illumination designation 4 should be used for the phakic eye, and the object size designation IV and illumination designation 4 for the aphakic eye.

Field measurements must be accompanied by notated field charts, a description of the type and size of the target and the test distance. Tangent screen visual fields are not acceptable as a measurement of peripheral field loss.

Where the loss is predominantly in the lower visual fields, a system such as the weighted grid scale for perimetric fields described by B. Esterman (see Grid for Scoring Visual Fields, II. Perimeter, *Archives of Ophthalmology,* 79:400, 1968) may be used for determining whether the visual field loss is comparable to that described in table 2.

4. *Muscle function.* Paralysis of the third cranial nerve producing ptosis, paralysis of accommodation, and dilation and immobility of the pupil may cause significant visual impairment. When all the muscle of the eye are paralyzed including the iris and ciliary body (total ophthalmoplegia), the condition is considered a severe impairment provided it is bilateral. A finding of severe impairment based primarily on impaired muscle function must be supported by a report of an actual measurement of ocular motility.

5. *Visual efficiency.* Loss of visual efficiency may be caused by disease or injury resulting in a reduction of central visual acuity or visual field. The visual efficiency of one eye is the product of the percentage of central visual efficiency and the percentage of visual field efficiency. (See tables no. 1 and 2, following 2.09.)

6. *Special situations.* Aphakia represents a visual handicap in addition to the loss of central visual acuity. The term monocular aphakia would apply to an individual who has had the lens removed from one eye, and who still retains the lens in his other eye, or to an individual who has only one eye which is aphakic. The term binocular aphakia would apply to an individual who has had both lenses removed. In cases of binocular aphakia, the central efficiency of the better eye will be accepted as 75 percent of its value. In cases of monocular aphakia, where the better eye is aphakic, the central visual efficiency will be accepted as 50 percent of the value. (If an individual has binocular aphakia, and the central visual acuity in the poorer eye can be corrected only to 20/200, or less, the central visual efficiency of the better eye will be accepted as 50 percent of its value.)

Ocular symptoms of systemic disease may or may not produce a disabling visual impairement. These manifestations should be evaluated as part of the underlying disease entity by reference to the particular body system involved.

7. *Statutory blindness.* The term ''statutory blindness'' refers to the degree of visual impairment which defines the term ''blindness'' in the Social Security Act. Both 2.02 and 2.03 A and B denote statutory blindness.

B. *Otolaryngology*

1. *Hearing impairment.* Hearing ability should be evaluated in terms of the person's ability to hear and distinguish speech.

Loss of hearing can be quantitatively determined by an audiometer which meets the standards of the American National Standards Institute (ANSI) for air and bone conducted stimuli (i.e., ANSI S 3.6–1969 and ANSI S 3.13–1972, or subsequent comparable revisions) and performing all hearing measurements in an environment which meets the ANSI standard for maximal permissible background sound (ANSI S 3.1–1977).

Speech discrimination should be determined using a standardized measure of speech discrimination ability in quiet at a test presentation level sufficient to ascertain maximum discrimination ability. The speech discrimination measure (test) used, and the level at which testing was done, must be reported.

Hearing tests should be preceded by an otolaryngologic examination and should be performed by or under the supervision of an otolaryngologist or audiologist qualified to perform such tests.

In order to establish an independent medical judgment as to the level of impairment in a claimant alleging deafness, the following examinations should be reported: Otolaryngologic examination, pure tone air and bone audiometry, speech reception threshold (SRT), and speech discrimination testing. A copy of reports of medical examination and audiologic evaluations must be submitted.

Cases of alleged ''deaf mutism'' should be documented by a hearing evaluation. Records obtained from a speech and hearing rehabilitation center or a special school for the deaf may be acceptable, but if these reports are not available, or are found to be inadequate, a current hearing evaluation should be submitted as outlined in the preceding paragraph.

2. *Vertigo associated with disturbances of labyrinthine-vestibular function, including Meniere's disease.* These disturbances of balance are characterized by an hallucination of motion or loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of ''dizziness'' which is described as lightheadedness, unsteadiness, confusion, or syncope.

Meniere's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be longlasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular functions is assessed by positional and caloric testing, preferably by electronystagmography. When polytograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to reports of skull and temporal bone X-rays.

3. *Organic loss of speech.* Glossectomy or laryngectomy or cicatricial laryngeal stenosis due to injury or infection results in loss of voice production by normal means. In evaluating organic loss of speech (see 2.09), ability to produce speech by any means includes the use of mechanical or electronic devices. Impairment of speech due to neurologic disorders should be evaluated under 11.00–11.19.

2.01 Category of Impairments, Special Senses and Speech

2.02 *Impairment of central visual acuity.* Remaining vision in the better eye after best correction is 20/200 or less.

2.03 *Contraction of peripheral visual fields in the better eye.*

A. To 10° or less from the point of fixation; or

B. So the widest diameter subtends an angle no greater than 20°; or

C. To 20 percent or less visual field efficiency.

2.04 *Loss of visual efficiency.* Visual efficiency of better eye after best correction 20 percent or less. (The percent of remaining visual efficiency=the product of the percent of remaining central visual efficiency and the percent of remaining visual field efficiency.)

2.05 *Complete homonymous hemianopsia* (with or without macular sparing). Evaluate under 2.04.

2.06 *Total bilateral ophthalmoplegia.*

2.07 *Disturbance of labyrinthine-vestibular function (including Meniere's disease),* characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.08 *Hearing impairments* (hearing not restorable by a hearing aid) manifested by:

A. Average hearing threshold sensitivity for air conduction of 90 decibels or greater and for bone conduction to corresponding maximal levels, in the better ear, determined by the simple average of hearing

threshold levels at 500, 1000 and 2000 hz. (see 2.00B1); or

B. Speech discrimination scores of 40 percent or less in the better ear;

2.09 *Organic loss of speech* due to any cause with inability to produce by any means speech which can be heard, understood, and sustained.

TABLE NO. 1—PERCENTAGE OF CENTRAL VISUAL EFFICIENCY CORRESPONDING TO CENTRAL VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)

Snellen		Percent central visual efficiency		
English	Metric	Phakic [1]	Aphakic monocular [2]	Aphakic binocular [3]
20/16	6/5	100	50	75
20/20	6/6	100	50	75
20/25	6/7.5	95	47	71
20/32	6/10	90	45	67
20/40	6/12	85	42	64
20/50	6/15	75	37	56
20/64	6/20	65	32	49

TABLE NO. 1—PERCENTAGE OF CENTRAL VISUAL EFFICIENCY CORRESPONDING TO CENTRAL VISUAL ACUITY NOTATIONS FOR DISTANCE IN THE PHAKIC AND APHAKIC EYE (BETTER EYE)—Continued

Snellen		Percent central visual efficiency		
English	Metric	Phakic [1]	Aphakic monocular [2]	Aphakic binocular [3]
20/80	6/24	60	30	45
20/100	6/30	50	25	37
20/125	6/38	40	20	30
20/160	6/48	30	.....	22
20/200	6/60	20	.....	.....

Column and Use.

[1] Phakic.—1. A lens is present in both eyes. 2. A lens is present in the better eye and absent in the poorer eye. 3. A lens is present in one eye and the other eye is enucleated.

[2] Monocular.—1. A lens is absent in the better eye and present in the poorer eye. 2. The lenses are absent in both eyes; however, the central visual acuity in the poorer eye after best correction in 20/200 or less. 3. A lens is absent from one eye and the other eye is enucleated.

[3] Binocular.—1. The lenses are absent from both eyes and the central visual acuity in the poorer eye after best correction is greater than 20/200.

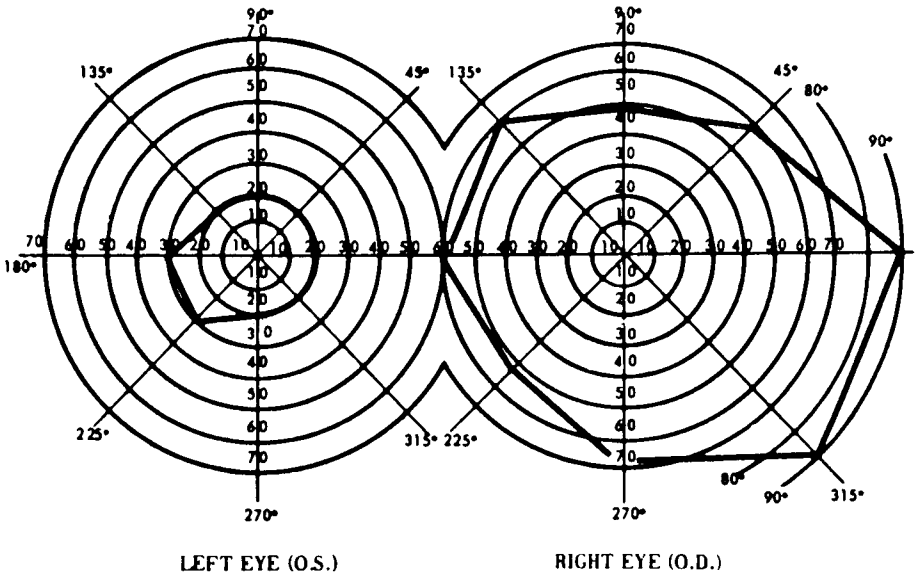

TABLE NO. 2—CHART OF VISUAL FIELD SHOWING EXTENT OF NORMAL FIELD AND METHOD OF COMPUTING PERCENT OF VISUAL FIELD EFFICIENCY

1. Diagram of right eye illustrates extent of normal visual field as tested on standard perimeter at 3/330 (3 mm. white disc at a distance of 330 mm.) under 7 foot-candles illumination. The sum of the eight principal meridians of this field total 500°.

2. The percent of visual field efficiency is obtained by adding the number of degrees of

the eight principal meridians of the contracted field and dividing by 500. Diagram of left eye illustrates visual field contracted to 30° in the temporal and down and out meridians and to 20° in the remaining six meridians. The percent of visual field efficiency of this field is: $6\times20+2\times30 =180\div500=0.36$ or 36 percent remaining visual field efficiency, or 64 percent loss.

3.00 Respiratory System

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorders based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the impairment.

Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response, because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). An individual who does not receive treatment may or may not be able to show the existence of an impairment that meets the criteria of these listings. Even if an individual does not show that his or her impairment meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a limited residual functional capacity. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the individual's functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Impairments caused by chronic disorders of the respiratory system generally produce irreversible loss of pulmonary function due to ventilatory impairments, gas exchange abnormalities, or a combination of both. The most common symptoms attributable to these disorders are dyspnea on exertion, cough, wheezing, sputum production, hemoptysis, and chest pain. Because these symptoms are common to many other diseases, a thorough medical history, physical examination, and chest x-ray or other appropriate imaging technique are required to establish chronic pulmonary disease. Pulmonary function testing is required to assess the severity of the respiratory impairment once a disease process is established by appropriate clinical and laboratory findings.

Alterations of pulmonary function can be due to obstructive airway disease (e.g., emphysema, chronic bronchitis, asthma), restrictive pulmonary disorders with primary loss of lung volume (e.g., pulmonary resection, thoracoplasty, chest cage deformity as in kyphoscoliosis or obesity), or infiltrative interstitial disorders (e.g., diffuse pulmonary fibrosis). Gas exchange abnormalities without significant airway obstruction can be produced by interstitial disorders. Disorders involving the pulmonary circulation (e.g., primary pulmonary hypertension, recurrent thromboembolic disease, primary or secondary pulmonary vasculitis) can produce pulmonary vascular hypertension and, eventually, pulmonary heart disease (cor pulmonale) and right heart failure. Persistent hypoxemia produced by any chronic pulmonary disorder also can result in chronic pulmonary hypertension and right heart failure. Chronic infection, caused most frequently by mycobacterial or mycotic organisms, can produce extensive and progressive lung destruction resulting in marked loss of pulmonary function. Some disorders, such as bronchiectasis, cystic fibrosis, and asthma, can be associated with intermittent exacerbations of such frequency and intensity that they produce a disabling impairment, even when pulmonary function during periods of relative clinical stability is relatively well-maintained.

Respiratory impairments usually can be evaluated under these listings on the basis of a complete medical history, physical examination, a chest x-ray or other appropriate imaging techniques, and spirometric pulmonary function tests. In some situations, most typically with a diagnosis of diffuse interstitial fibrosis or clinical findings suggesting cor pulmonale, such as cyanosis or secondary polycythemia, an impairment may be underestimated on the basis of spirometry alone. More sophisticated pulmonary function testing may then be necessary to determine if gas exchange abnormalities contribute to the severity of a respiratory impairment. Additional testing might include measurement of diffusing capacity of the lungs for carbon monoxide or resting arterial blood gases. Measurement of

arterial blood gases during exercise is required infrequently. In disorders of the pulmonary circulation, right heart catheterization with angiography and/or direct measurement of pulmonary artery pressure may have been done to establish a diagnosis and evaluate severity. When performed, the results of the procedure should be obtained. Cardiac catheterization will not be purchased.

These listings are examples of common respiratory disorders that are severe enough to prevent a person from engaging in any gainful activity. When an individual has a medically determinable impairment that is not listed, an impairment which does not meet a listing, or a combination of impairments no one of which meets a listing, we will consider whether the individual's impairment or combination of impairments is medically equivalent in severity to a listed impairment. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals will proceed through the final steps of the sequential evaluation process.

B. *Mycobacterial, mycotic, and other chronic persistent infections of the lung.* These disorders are evaluated on the basis of the resulting limitations in pulmonary function. Evidence of chronic infections, such as active mycobacterial diseases or mycoses with positive cultures, drug resistance, enlarging parenchymal lesions, or cavitation, is not, by itself, a basis for determining that an individual has a disabling impairment expected to last 12 months. In those unusual cases of pulmonary infection that persist for a period approaching 12 consecutive months, the clinical findings, complications, therapeutic considerations, and prognosis must be carefully assessed to determine whether, despite relatively well-maintained pulmonary function, the individual nevertheless has an impairment that is expected to last for at least 12 consecutive months and prevent gainful activity.

C. *Episodic respiratory disease.* When a respiratory impairment is episodic in nature, as can occur with exacerbations of asthma, cystic fibrosis, bronchiectasis, or chronic asthmatic bronchitis, the frequency and intensity of episodes that occur despite prescribed treatment are often the major criteria for determining the level of impairment. Documentation for these exacerbations should include available hospital, emergency facility and/or physician records indicating the dates of treatment; clinical and laboratory findings on presentation, such as the results of spirometry and arterial blood gas studies (ABGS); the treatment administered; the time period required for treatment; and the clinical response. Attacks of asthma, episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum), or respiratory failure as referred to in paragraph B of 3.03, 3.04, and 3.07, are defined as prolonged symptomatic episodes lasting one or more days and requiring intensive treatment, such as intravenous bronchodilator or antibiotic administration or prolonged inhalational bronchodilator therapy in a hospital, emergency room or equivalent setting. Hospital admissions are defined as inpatient hospitalizations for longer than 24 hours. The medical evidence must also include information documenting adherence to a prescribed regimen of treatment as well as a description of physical signs. For asthma, the medical evidence should include spirometric results obtained between attacks that document the presence of baseline airflow obstruction.

D. *Cystic fibrosis* is a disorder that affects either the respiratory or digestive body systems or both and is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis procedure for collection of sweat content must be utilized. Two methods are acceptable: the ''Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis'' published by the Cystic Fibrosis Foundation and contained in, ''A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis,'' Gibson, I.E., and Cooke, R.E., *Pediatrics,* Vol. 23: 545, 1959; or the ''Wescor Macroduct System.'' To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the ''CF gene mutation analysis'' for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 3.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the digestive body system (5.00). Because cystic fibrosis may involve the respiratory and digestive body systems, the combined effects of the involvement of these body systems must be considered in case adjudication.

E. *Documentation of pulmonary function testing.* The results of spirometry that are used for adjudication under paragraphs A and B of 3.02 and paragraph A of 3.04 should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory

volume (FEV_1) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirograms should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV_1 and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV_1 and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV_1 if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV_1 value is less than 70 percent of the predicted normal value. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the individual is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. The effect of the administered bronchodilator in relieving bronchospasm and improving ventilatory function is assessed by spirometry. If a bronchodilator is not administered, the reason should be clearly stated in the report. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents any gainful work activity, unless the use of bronchodilators is contraindicated. Post-bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in paragraphs A and B of 3.02 must only be used as criteria for the level of ventilatory impairment that exists during the individual's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the claimant's name, date of testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/6 sec), 60 L/min (3 L/3 sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the individual should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the individual's actual spirograms.

The spirogram must be recorded at a speed of at least 20 mm/sec, and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV_1 from a flow-volume tracing is not acceptable, i.e., the spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the individual's ability to understand directions as well as his or her effort and cooperation in performing the pulmonary function tests.

The pulmonary function tables in 3.02 and 3.04 are based on measurement of standing height without shoes. If an individual has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities abducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

F. *Documentation of chronic impairment of gas exchange.*

1. *Diffusing capacity of the lungs for carbon monoxide (DLCO).* A diffusing capacity of the lungs for carbon monoxide study should be purchased in cases in which there is documentation of chronic pulmonary disease, but

the existing evidence, including properly performed spirometry, is not adequate to establish the level of functional impairment. Before purchasing DLCO measurements, the medical history, physical examination, reports of chest x-ray or other appropriate imaging techniques, and spirometric test results must be obtained and reviewed because favorable decisions can often be made based on available evidence without the need for DLCO studies. Purchase of a DLCO study may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The DLCO should be measured by the single breath technique with the individual relaxed and seated. At sea level, the inspired gas mixture should contain approximately 0.3 percent carbon monoxide (CO), 10 percent helium (He), 21 percent oxygen (O_2), and the balance nitrogen. At altitudes above sea level, the inspired O_2 concentration may be raised to provide an inspired O_2 tension of approximately 150 mm Hg. Alternatively, the sea level mixture may be employed at altitude and the measured DLCO corrected for ambient barometric pressure. Helium may be replaced by another inert gas at an appropriate concentration. The inspired volume (VI) during the DLCO maneuver should be at least 90 percent of the previously determined vital capacity (VC). The inspiratory time for the VI should be less than 2 seconds, and the breath-hold time should be between 9 and 11 seconds. The washout volume should be between 0.75 and 1.00 L, unless the VC is less than 2 L. In this case, the washout volume may be reduced to 0.50 L; any such change should be noted in the report. The alveolar sample volume should be between 0.5 and 1.0 L and be collected in less than 3 seconds. At least 4 minutes should be allowed for gas washout between repeat studies.

A DLCO should be reported in units of ml CO, standard temperature, pressure, dry (STPD)/min/mm Hg uncorrected for hemoglobin concentration and be based on a single-breath alveolar volume determination. Abnormal hemoglobin or hematocrit values, and/or carboxyhemoglobin levels should be reported along with diffusing capacity.

The DLCO value used for adjudication should represent the mean of at least two acceptable measurements, as defined above. In addition, two acceptable tests should be within 10 percent of each other or 3 ml CO(STPD)/min/mm Hg, whichever is larger. The percent difference should be calculated as 100×(test 1 − test 2)/average DLCO.

The ability of the individual to follow directions and perform the test properly should be described in the written report. The report should include tracings of the VI, breath-hold maneuver, and VE appropriately labeled with the name of the individual and the date of the test. The time axis should be at least 20 mm/sec and the volume axis at least 10 mm/L. The percentage concentrations of inspired O_2, and inspired and expired CO and He for each of the maneuvers should be provided, and the algorithm used to calculate test results noted. Sufficient data must be provided to permit independent calculation of results (and, if necessary, calculation of corrections for anemia and/or carboxyhemoglobin).

2. *Arterial blood gas studies (ABGS).* An ABGS performed at rest (while breathing room air, awake and sitting or standing) or during exercise should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. If the results of a DLCO study are greater than 40 percent of predicted normal but less than 60 percent of predicted normal, purchase of resting ABGS should be considered. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of patients with pulmonary disease, must review all clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the individual.

3. *Exercise testing.* Exercise testing with measurement of arterial blood gases during exercise may be appropriate in cases in which there is documentation of chronic pulmonary disease, but full development, short of exercise testing, is not adequate to establish if the impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. In this context, ''full development'' means that results from spirometry and measurement of DLCO and resting ABGS have been obtained from treating sources or through purchase. Exercise arterial blood gas measurements will be required infrequently and should be purchased only after careful review of the medical history, physical examination, chest x-ray or other appropriate imaging techniques, spirometry, DLCO, electrocardiogram (ECG), hematocrit or hemoglobin, and resting blood gas results by a program physician, preferably one experienced in the care of patients with pulmonary disease, to determine whether obtaining the test would presents a significant risk to the individual. Oximetry and capillary blood gas analysis are not acceptable substitutes for the measurement of

arterial blood gases. Arterial blood gas samples obtained after the completion of exercise are not acceptable for establishing an individual's functional capacity.

Generally, individuals with a DLCO greater than 60 percent of predicted normal would not be considered for exercise testing with measurement of blood gas studies. The exercise test facility must be provided with the claimant's clinical records, reports of chest x-ray or other appropriate imaging techniques, and any spirometry, DLCO, and resting blood gas results obtained as evidence of record. The testing facility must determine whether exercise testing present a significant risk to the individual; if it does, the reason for not performing the test must be reported in writing.

4. *Methodology*. Individuals considered for exercise testing first should have resting arterial blood partial pressure of oxygen (PO_2), resting arterial blood partial pressure of carbon dioxide (PCO_2) and negative log of hydrogen ion concentration (pH) determinations by the testing facility. The sample should be obtained in either the sitting or standing position. The individual should then perform exercise under steady state conditions, preferably on a treadmill, breathing room air, for a period of 4 to 6 minutes at a speed and grade providing an oxygen consumption of approximately 17.5 ml/kg/min (5 METs). If a bicycle ergometer is used, an exercise equivalent of 5 METs (e.g., 450 kpm/min, or 75 watts, for a 176 pound (80 kilogram) person) should be used. If the individual is able to complete this level of exercise without achieving listing-level hypoxemia, then he or she should be exercised at higher workloads to determine exercise capacity. A warm-up period of treadmill walking or cycling may be performed to acquaint the individual with the exercise procedure. If during the warm-up period the individual cannot achieve an exercise level of 5 METs, a lower workload may be selected in keeping with the estimate of exercise capacity. The individual should be monitored by ECG throughout the exercise and in the immediate post-exercise period. Blood pressure and an ECG should be recorded during each minute of exercise. During the final 2 minutes of a specific level of steady state exercise, an arterial blood sample should be drawn and analyzed for oxygen pressure (or tension) (PO_2), carbon dioxide pressure (or tension) (PCO_2), and pH. At the discretion of the testing facility, the sample may be obtained either from an indwelling arterial catheter or by direct arterial puncture. If possible, in order to evaluate exercise capacity more accurately, a test site should be selected that has the capability to measure minute ventilation, O_2 consumption, and carbon dioxide (CO_2) production. If the claimant fails to complete 4 to 6 minutes of steady state exercise, the testing laboratory should comment on the reason and report the actual duration and levels of exercise performed. This comment is necessary to determine if the individual's test performance was limited by lack of effort or other impairment (e.g., cardiac, peripheral vascular, musculoskeletal, neurological).

The exercise test report should contain representative ECG strips taken before, during and after exercise; resting and exercise arterial blood gas values; treadmill speed and grade settings, or, if a bicycle ergometer was used, exercise levels expressed in watts or kpm/min; and the duration of exercise. Body weight also should be recorded. If measured, O_2 consumption (STPD), minute ventilation (BTPS), and CO_2 production (STPD) also should be reported. The altitude of the test site, its normal range of blood gas values, and the barometric pressure on the test date must be noted.

G. *Chronic cor pulmonale and pulmonary vascular disease*. The establishment of an impairment attributable to irreversible cor pulmonale secondary to chronic pulmonary hypertension requires documentation by signs and laboratory findings of right ventricular overload or failure (e.g., an early diastolic right-sided gallop on auscultation, neck vein distension, hepatomegaly, peripheral edema, right ventricular outflow tract enlargement on x-ray or other appropriate imaging techniques, right ventricular hypertrophy on ECG, and increased pulmonary artery pressure measured by right heart catheterization available from treating sources). Cardiac catheterization will not be purchased. Because hypoxemia may accompany heart failure and is also a cause of pulmonary hypertension, and may be associated with hypoventilation and respiratory acidosis, arterial blood gases may demonstrate hypoxemia (decreased PO_2), CO_2 retention (increased PCO_2), and acidosis (decreased pH). Polycythemia with an elevated red blood cell count and hematocrit may be found in the presence of chronic hypoxemia.

P-pulmonale on the ECG does not establish chronic pulmonary hypertension or chronic cor pulmonale. Evidence of florid right heart failure need not be present at the time of adjudication for a listing (e.g., 3.09) to be satisfied, but the medical evidence of record should establish that cor pulmonale is chronic and irreversible.

H. *Sleep-related breathing disorders*. Sleep-related breathing disorders (sleep apneas) are caused by periodic cessation of respiration associated with hypoxemia and frequent arousals from sleep. Although many individuals with one of these disorders will respond to prescribed treatment, in some, the disturbed sleep pattern and associated chronic nocturnal hypoxemia cause daytime sleepiness with chronic pulmonary hypertension and/or disturbances in cognitive function.

Because daytime sleepiness can affect memory, orientation, and personality, a longitudinal treatment record may be needed to evaluate mental functioning. Not all individuals with sleep apnea develop a functional impairment that affects work activity. When any gainful work is precluded, the physiologic basis for the impairment may be chronic cor pulmonale. Chronic hypoxemia due to episodic apnea may cause pulmonary hypertension (see 3.00G and 3.09). Daytime somnolence may be associated with disturbance in cognitive vigilance. Impairment of cognitive function may be evaluated under organic mental disorders (12.02).

I. *Effects of obesity*. Obesity is a medically determinable impairment that is often associated with disturbance of the respiratory system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with respiratory impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

3.01 Category of Impairments, Respiratory System.

3.02 *Chronic pulmonary insufficiency*.

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV_1 equal to or less than the values specified in table I corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
154 or less	60 or less	1.05
155–160	61–63	1.15
161–165	64–65	1.25
166–170	66–67	1.35
171–175	68–69	1.45
176–180	70–71	1.55
181 or more	72 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the values specified in table II corresponding to the person's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L, BTPS)
154 or less	60 or less	1.25
155–160	61–63	1.35
161–165	64–65	1.45
166–170	66–67	1.55
171–175	68–69	1.65
176–180	70–71	1.75
181 or more	72 or more	1.85

Or

C. Chronic impairment of gas exchange due to clinically documented pulmonary disease. With:

1. Single breath DLCO (see 3.00F1) less than 10.5 ml/min/mm Hg or less than 40 percent of the predicted normal value. (Predicted values must either be based on data obtained at the test site or published values from a laboratory using the same technique as the test site. The source of the predicted values should be reported. If they are not published, they should be submitted in the form of a table or nomogram); or

2. Arterial blood gas values of PO_2 and simultaneously determined PCO_2 measured while at rest (breathing room air, awake and sitting or standing) in a clinically stable condition on at least two occasions, three or more weeks apart within a 6-month period, equal to or less than the values specified in the applicable table III–A or III–B or III–C:

TABLE III—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55

TABLE III—B—Continued

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 or equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

Or

3. Arterial blood gas values of PO_2 and simultaneously determined PCO_2 during steady state exercise breathing room air (level of exercise equivalent to or less than 17.5 ml O_2 consumption/kg/min or 5 METs) equal to or less than the values specified in the applicable table III–A or III–B or III–C in 3.02C2.

3.03 Asthma. With:

A. Chronic asthmatic bronchitis. Evaluate under the criteria for chronic obstructive pulmonary disease in 3.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each in-patient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks.

3.04 Cystic fibrosis. With:

A. An FEV_1 equal to or less than the appropriate value specified in table IV corresponding to the individual's height without shoes. (In cases of marked spinal deformity, see 3.00E.);

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial therapy.

TABLE IV

[Applicable only for evaluation under 3.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
154 or less	60 or less	1.45
155–159	61–62	1.55
160–164	63–64	1.65
165–169	65–66	1.75
170–174	67–68	1.85
175–179	69–70	1.95
180 or more	71 or more	2.05

3.05 [Reserved]

3.06 *Pneumoconiosis* (demonstrated by appropriate imaging techniques). Evaluate under the appropriate criteria in 3.02.

3.07 *Bronchiectasis* (demonstrated by appropriate imaging techniques). With:

A. Impairment of pulmonary function due to extensive disease. Evaluate under the appropriate criteria in 3.02;

Or

B. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation of at least 12 consecutive months must be used to determine the frequency of episodes.

3.08 *Mycobacterial, mycotic, and other chronic persistent infections of the lung* (see 3.00B). Evaluate under the appropriate criteria in 3.02.

3.09 *Cor pulmonale secondary to chronic pulmonary vascular hypertension.* Clinical evidence of cor pulmonale (documented according to 3.00G) with:

A. Mean pulmonary artery pressure greater than 40 mm Hg;

Or

B. Arterial hypoxemia. Evaluate under the criteria in 3.02C2;

Or

C. Evaluate under the applicable criteria in 4.02.

3.10 *Sleep-related breathing disorders.* Evaluate under 3.09 (chronic cor pulmonale) or 12.02 (organic mental disorders).

4.00 CARDIOVASCULAR SYSTEM

A. *Introduction.* The listings in this section describe impairments resulting from cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration of cardiovascular impairment, unless the claim can be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing disability.

Many individuals, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the individual's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some individuals will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the degree of recovery from cardiac insult, the level of the individual's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though an individual who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the individual may have an impairment(s) equivalent in severity to one of the listed impairments or be disabled because of a limited residual functional capacity.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to prevent a person from engaging in gainful activity. Therefore, in any case in which an individual has a medically determinable impairment that is not listed, or a combination of impairments no one of which meets a listing, we will make a medical equivalence determination. Individuals who have an impairment(s) with a level of severity which does not meet or equal the criteria of the cardiovascular listings may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful activity. Evaluation of the impairment(s) of these individuals should proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard).

B. *Cardiovascular impairment* results from one or more of four consequences of heart disease:

1. Chronic heart failure or ventricular dysfunction.

2. Discomfort or pain due to myocardial ischemia, with or without necrosis of heart muscle.

3. Syncope, or near syncope, due to inadequate cerebral perfusion from any cardiac cause such as obstruction of flow or disturbance in rhythm or conduction resulting in inadequate cardiac output.

4. Central cyanosis due to right-to-left shunt, arterial desaturation, or pulmonary vascular disease.

Impairment from diseases of arteries and veins may result from disorders of the vasculature in the central nervous system (11.04A, B), eyes (2.02–2.04), kidney (6.02), and other organs.

C. *Documentation.* Each individual's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment.

1. Electrocardiography

a. An original or legible copy of the 12-lead electrocardiogram (ECG) obtained at rest must be submitted, appropriately dated and labeled, with the standardization inscribed on the tracing. Alteration in standardization of specific leads (such as to accommodate large QRS amplitudes) must be identified on those leads.

(1) Detailed descriptions or computer-averaged signals without original or legible copies of the ECG as described in subsection 4.00Cla are not acceptable.

(2) The effects of drugs or electrolyte abnormalities must be considered as possible noncoronary causes of ECG abnormalities of ventricular repolarization, i.e., those involving the ST segment and T wave. If available, the predrug (especially digitalis glycoside) ECG should be submitted.

(3) The term ''ischemic'' is used in 4.04A to describe an abnormal ST segment deviation. Nonspecific repolarization abnormalities should not be confused with ''ischemic'' changes.

b. ECGs obtained in conjunction with treadmill, bicycle, or arm exercise tests should meet the following specifications:

(1) ECGs must include the original calibrated ECG tracings or a legible copy.

(2) A 12-lead baseline ECG must be recorded in the upright position before exercise.

(3) A 12-lead ECG should be recorded at the end of each minute of exercise, including at the time the ST segment abnormalities reach or exceed the criteria for abnormality described in 4.04A or the individual experiences chest discomfort or other abnormalities, and also when the exercise test is terminated.

(4) If ECG documentation of the effects of hyperventilation is obtained, the exercise test should be deferred for at least 10 minutes because metabolic changes of hyperventilation may alter the physiologic and ECG response to exercise.

(5) Post-exercise ECGs should be recorded using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice.

(6) All resting, exercise, and recovery ECG strips must have a standardization inscribed on the tracing. The ECG strips should be labeled to indicate the times recorded and the relationship to the stage of the exercise protocol. The speed and grade (treadmill test) or work rate (bicycle or arm ergometric test) should be recorded. The highest level of exercise achieved, blood pressure levels during testing, and the reason(s) for terminating the test (including limiting signs or symptoms) must be recorded.

2. Purchasing Exercise Tests

a. It is well recognized by medical experts that exercise testing is the best tool currently available for estimating maximal aerobic capacity in individuals with cardiovascular impairments. Purchase of an exercise test may be appropriate when there is a question whether an impairment meets or is equivalent in severity to one of the listings, or when there is insufficient evidence in the record to evaluate aerobic capacity, and the claim cannot otherwise be favorably decided. Before purchasing an exercise test, a program physician, preferably one with experience in the care of patients with cardiovascular disease, must review the pertinent history, physical examinations, and laboratory tests to determine whether obtaining the test would present a significant risk to the individual (see 4.00C2c). Purchase may be indicated when there is no significant risk to exercise testing and there is no timely test of record. An exercise test is generally considered timely for 12 months after the date performed, provided there has been no change in clinical status that may alter the severity of the cardiac impairment.

b. *Methodology.*

(1) When an exercise test is purchased, it should be a ''sign-or symptom-limited'' test characterized by a progressive multistage regimen. A purchased exercise test must be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. A description of the protocol that was followed must be provided, and the test must meet the requirements of 4.00C1b and this section. A pre-exercise posthyperventilation tracing may be essential for the proper evaluation of an ''abnormal'' test in certain circumstances, such as in women with evidence of mitral valve prolapse.

(2) The exercise test should be paced to the capabilities of the individual and be supervised by a physician. With a treadmill test, the speed, grade (incline) and duration of exercise must be recorded for each exercise test stage performed. Other exercise test protocols or techniques that are used should utilize similar workloads.

(3) Levels of exercise should be described in terms of workload and duration of each stage, e.g., treadmill speed and grade, or bicycle ergometer work rate in kpm/min or watts.

(4) Normally, systolic blood pressure and heart rate increase gradually with exercise. A decrease in systolic blood pressure during exercise below the usual resting level is often associated with ischemia-induced left ventricular dysfunction resulting in decreased cardiac output. Some individuals (because of deconditioning or apprehension) with increased sympathetic responses may increase their systolic blood pressure and heart rate above their usual resting level just before and early into exercise. This occurrence may limit the ability to assess the significance of an early decrease in systolic blood pressure and heart rate if exercise is discontinued shortly after initiation. In addition, isolated systolic hypertension may be a manifestation of arteriosclerosis.

(5) The exercise laboratory's physical environment, staffing, and equipment should meet the generally accepted standards for adult exercise test laboratories.

c. *Risk factors in exercise testing.* The following are examples of situations in which exercise testing will not be purchased: unstable progressive angina pectoris, a history of acute myocardial infarction within the past 3 months, New York Heart Association (NYHA) class IV heart failure, cardiac drug toxicity, uncontrolled serious arrhythmia (including uncontrolled atrial fibrillation, Mobitz II, and third-degree block), Wolff-Parkinson-White syndrome, uncontrolled severe systemic arterial hypertension, marked pulmonary hypertension, unrepaired aortic dissection, left main stenosis of 50 percent or greater, marked aortic stenosis, chronic or

dissecting aortic aneurysm, recent pulmonary embolism, hypertrophic cardiomyopathy, limiting neurological or musculoskeletal impairments, or an acute illness. In addition, an exercise test should not be purchased for individuals for whom the performance of the test is considered to constitute a significant risk by a program physician, preferably one experienced in the care of patients with cardiovascular disease, even in the absence of any of the above risk factors. In defining risk, the program physician, in accordance with the regulations and other instructions on consultative examinations, will generally give great weight to the treating physicians' opinions and will generally not override them. In the rare situation in which the program physician does override the treating source's opinion, a written rationale must be prepared documenting the reasons for overriding the opinion.

d. In order to permit maximal, attainable restoration of functional capacity, exercise testing should not be purchased until 3 months after an acute myocardial infarction, surgical myocardial revascularization, or other open-heart surgical procedures. Purchase of an exercise test should also be deferred for 3 months after percutaneous transluminal coronary angioplasty because restenosis with ischemic symptoms may occur within a few months of angioplasty (see 4.00D). Also, individuals who have had a period of bedrest or inactivity (e.g., 2 weeks) that results in a reversible deconditioned state may do poorly if exercise testing is performed at that time.

e. *Evaluation.*

(1) Exercise testing is evaluated on the basis of the work level at which the test becomes abnormal, as documented by onset of signs or symptoms and any ECG abnormalities listed in 4.04A. The ability or inability to complete an exercise test is not, by itself, evidence that a person is free from ischemic heart disease. The results of an exercise test must be considered in the context of all of the other evidence in the individual's case record. If the individual is under the care of a treating physician for a cardiac impairment, and this physician has not performed an exercise test and there are no reported significant risks to testing (see 4.00C2c), a statement should be requested from the treating physician explaining why it was not done or should not be done before deciding whether an exercise test should be purchased. In those rare situations in which the treating source's opinion is overridden, follow 4.00C2c. If there is no treating physician, the program physician will be responsible for assessing the risk to exercise testing.

(2) Limitations to exercise test interpretation include the presence of noncoronary or nonischemic factors that may influence the hemodynamic and ECG response to exercise, such as hypokalemia or other electrolyte abnormality, hyperventilation, vasoregulatory deconditioning, prolonged periods of physical inactivity (e.g., 2 weeks of bedrest), significant anemia, left bundle branch block pattern on the ECG (and other conduction abnormalities that do not preclude the purchase of exercise testing), and other heart diseases or abnormalities (particularly valvular heart disease). Digitalis glycosides may cause ST segment abnormalities at rest, during, and after exercise. Digitalis or other drug-related ST segment displacement, present at rest, may become accentuated with exercise and make ECG interpretation difficult, but such drugs do not invalidate an otherwise normal exercise test. Diuretic-induced hypokalemia and left ventricular hypertrophy may also be associated with repolarization changes and behave similarly. Finally, treatment with beta blockers slows the heart rate more at near-maximal exertion than at rest; this limits apparent chronotropic capacity.

3. Other Studies

Information from two-dimensional and Doppler echocardiographic studies of ventricular size and function as well as radionuclide (thallium $_{201}$) myocardial ''perfusion'' or radionuclide (technetium 99m) ventriculograms (RVG or MUGA) may be useful. These techniques can provide a reliable estimate of ejection fraction. In selected cases, these tests may be purchased after a medical history and physical examination, report of chest x-rays, ECGs, and other appropriate tests have been evaluated, preferably by a program physician with experience in the care of patients with cardiovascular disease. Purchase should be considered when other information available is not adequate to assess whether the individual may have severe ventricular dysfunction or myocardial ischemia and there is no significant risk involved (follow 4.00C2a guides), and the claim cannot be favorably decided on any other basis.

Exercise testing with measurement of maximal oxygen uptake (VO_2) provides an accurate determination of aerobic capacity. An exercise test without measurement of oxygen uptake provides an estimate of aerobic capacity. When the results of tests with measurement of oxygen uptake are available, every reasonable effort should be made to obtain them.

The recording of properly calibrated ambulatory ECGs for analysis of ST segment signals with a concomitantly recorded symptom and treatment log may permit more adequate evaluation of chest discomfort during activities of daily living, but the significance of these data for disability evaluation has not been established in the absence of symptoms (e.g., silent ischemia). This information (including selected segments of both

the ECG recording and summary report of the patient diary) may be submitted for the record.

4. *Cardiac catheterization* will not be purchased by the Social Security Administration.

a. *Coronary arteriography*. If results of such testing are available, the report should be obtained and considered as to the quality and type of data provided and its relevance to the evaluation of the impairment. A copy of the report of the cardiac catheterization and ancillary studies should also be obtained. The report should provide information citing the method of assessing coronary arterial lumen diameter and the nature and location of obstructive lesions. Drug treatment at baseline and during the procedure should be reported. Coronary artery spasm induced by intracoronary catheterization is not to be considered evidence of ischemic disease. Some individuals with significant coronary atherosclerotic obstruction have collateral vessels that supply the myocardium distal to the arterial obstruction so that there is no evidence of myocardial damage or ischemia, even with exercise. When available, quantitative computer measurements and analyses should be considered in the interpretation of severity of stenotic lesions.

b. *Left ventriculography (by angiography)*. The report should describe the wall motion of the myocardium with regard to any areas of hypokinesis, akinesis, or dyskinesis, and the overall contraction of the ventricle as measured by the ejection fraction. Measurement of chamber volumes and pressures may be useful. When available, quantitative computer analysis provides precise measurement of segmental left ventricular wall thickness and motion. There is often a poor correlation between left ventricular function at rest and functional capacity for physical activity.

D. *Treatment and relationship to functional status.*

1. In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects. Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

2. The usual time after myocardial infarction, valvular and/or revascularization surgery for adequate assessment of the results of treatment is considered to be 3 months. If an exercise test is performed by a treating source within a week or two after angioplasty, and there is no significant change in clinical status during the 3-month period after the angioplasty that would invalidate the implications of the exercise test results, the exercise test results may be used to reflect functional capacity during the period in question. However, if the test was done immediately following an acute myocardial infarction or during a period of protracted inactivity, the results should not be projected to 3 months even if there is no change in clinical status.

3. An individual who has undergone cardiac transplantation will be considered under a disability for 1 year following the surgery because, during the first year, there is a greater likelihood of rejection of the organ and recurrent infection. After the first year posttransplantation, continuing disability evaluation will be based upon residual impairment as shown by symptoms, signs, and laboratory findings. Absence of symptoms, signs, and laboratory findings indicative of cardiac dysfunction will be included in the consideration of whether medical improvement (as defined in §§ 404.1579 (b)(1) and (c)(1), 404.1594 (b)(1) and (c)(1), or 416.994 (b)(1)(i) and (b)(2)(i), as appropriate) has occurred.

E. *Clinical syndromes.*

1. Chronic heart failure (ventricular dysfunction) is considered in these listings as one category whatever its etiology, i.e., atherosclerotic, hypertensive, rheumatic, pulmonary, congenital or other organic heart disease. Chronic heart failure may manifest itself by:

a. Pulmonary or systemic congestion, or both; or

b. Symptoms of limited cardiac output, such as weakness, fatigue, or intolerance of physical activity.

For the purpose of 4.02A, pulmonary and systemic congestion are not considered to have been established unless there is or has been evidence of fluid retention, such as hepatomegaly or ascites, or peripheral or pulmonary edema of cardiac origin. The findings of fluid retention need not be present at the time of adjudication because congestion may be controlled with medication. Chronic heart failure due to limited cardiac output is not considered to have been established for the purpose of 4.02B unless symptoms occur with ordinary daily activities, i.e., activity restriction as manifested by a need to decrease activity or pace, or to rest intermittently, and are associated with one or more

physical signs or abnormal laboratory studies listed in 4.02B. These studies include exercise testing with ECG and blood pressure recording and/or appropriate imaging techniques, such as two-dimensional echocardiography or radionuclide or contrast ventriculography. The exercise criteria are outlined in 4.02B1. In addition, other abnormal symptoms, signs, or laboratory test results that lend credence to the impression of ventricular dysfunction should be considered.

2. For the purposes of 4.03, hypertensive cardiovascular disease is evaluated by reference to the specific organ system involved (heart, brain, kidneys, or eyes). The presence of organic impairment must be established by appropriate physical signs and laboratory test abnormalities as specified in 4.02 or 4.04, or for the body system involved.

3. Ischemic (coronary) heart disease may result in an impairment due to myocardial ischemia and/or ventricular dysfunction or infarction. For the purposes of 4.04, the clinical determination that discomfort of myocardial ischemic origin (angina pectoris) is present must be supported by objective evidence as described under 4.00Cl, 2, 3, or 4.

a. Discomfort of myocardial ischemic origin (angina pectoris) is discomfort that is precipitated by effort and/or emotion and promptly relieved by sublingual nitroglycerin, other rapidly acting nitrates, or rest. Typically the discomfort is located in the chest (usually substernal) and described as crushing, squeezing, burning, aching, or oppressive. Sharp, sticking, or cramping discomfort is considered less common or atypical. Discomfort occurring with activity or emotion should be described specifically as to timing and usual inciting factors (type and intensity), character, location, radiation, duration, and response to nitrate therapy or rest.

b. So-called anginal equivalent may be localized to the neck, jaw(s), or hand(s) and has the same precipitating and relieving factors as typical chest discomfort. Isolated shortness of breath (dyspnea) is not considered an anginal equivalent for purposes of adjudication.

c. Variant angina of the Prinzmetal type, i.e., rest angina with transitory ST segment elevation on ECG, may have the same significance as typical angina, described in 4.00E3a.

d. If there is documented evidence of silent ischemia or restricted activity to prevent chest discomfort, this information must be considered along with all available evidence to determine if an equivalence decision is appropriate.

e. Chest discomfort of myocardial ischemic origin is usually caused by coronary artery disease. However, ischemic discomfort may be caused by noncoronary artery conditions, such as critical aortic stenosis, hypertrophic cardiomyopathy, pulmonary hypertension, or anemia. These conditions should be distinguished from coronary artery disease, because the evaluation criteria, management, and prognosis (duration) may differ from that of coronary artery disease.

f. Chest discomfort of nonischemic origin may result from other cardiac conditions such as pericarditis and mitral valve prolapse. Noncardiac conditions may also produce symptoms mimicking that of myocardial ischemia. These conditions include gastrointestinal tract disorders, such as esophageal spasm, esophagitis, hiatal hernia, biliary tract disease, gastritis, peptic ulcer, and pancreatitis, and musculoskeletal syndromes, such as chest wall muscle spasm, chest wall syndrome (especially after coronary bypass surgery), costochondritis, and cervical or dorsal arthritis. Hyperventilation may also mimic ischemic discomfort. Such disorders should be considered before concluding that chest discomfort is of myocardial ischemic origin.

4. Peripheral Arterial Disease

The level of impairment is based on the symptomatology, physical findings, Doppler studies before and after a standard exercise test, or angiographic findings.

The requirements for evaluating peripheral arterial disease in 4.12B are based on the ratio of the systolic blood pressure at the ankle to the systolic blood pressure at the brachial artery, determined in the supine position at the same time. Techniques for obtaining ankle systolic blood pressures include Doppler, plethysmographic studies, or other techniques.

Listing 4.12B1 is met when the resting ankle/brachial systolic blood pressure ratio is less than 0.50. Listing 4.12B2 provides additional criteria for evaluating peripheral arterial impairment on the basis of exercise studies when the resting ankle/brachial systolic blood pressure ratio is 0.50 or above. The decision to obtain exercise studies should be based on an evaluation of the existing clinical evidence, but exercise studies are rarely warranted when the resting ankle-over-brachial systolic blood pressure ratio is 0.80 or above. The results of exercise studies should describe the level of exercise, e.g., speed and grade of the treadmill settings, the duration of exercise, symptoms during exercise, the reasons for stopping exercise if the expected level of exercise was not attained, blood pressures at the ankle and other pertinent sites measured after exercise, and the time required to return the systolic blood pressure toward or to the pre-exercise level. When an exercise Doppler study is purchased by the Social Security Administration, the requested exercise must be on a treadmill at

2 mph on a 10 or 12 percent grade for 5 minutes. Exercise studies should not be performed on individuals for whom exercise poses a significant risk.

Application of the criteria in 4.12B may be limited in individuals who have marked calcific (Monckeberg's) sclerosis of the peripheral arteries or marked small vessel disease associated with diabetes mellitus.

F. *Effects of obesity.* Obesity is a medically determinable impairment that is often associated with disturbance of the cardiovascular system, and disturbance of this system can be a major cause of disability in individuals with obesity. The combined effects of obesity with cardiovascular impairments can be greater than the effects of each of the impairments considered separately. Therefore, when determining whether an individual with obesity has a listing-level impairment or combination of impairments, and when assessing a claim at other steps of the sequential evaluation process, including when assessing an individual's residual functional capacity, adjudicators must consider any additional and cumulative effects of obesity.

4.01 Category of Impairments, Cardiovascular System

4.02 *Chronic heart failure* while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Documented cardiac enlargement by appropriate imaging techniques (e.g., a cardiothoracic ratio of greater than 0.50 on a PA chest x-ray with good inspiratory effort or left ventricular diastolic diameter of greater than 5.5 cm on two-dimensional echocardiography), resulting in inability to carry on any physical activity, and with symptoms of inadequate cardiac output, pulmonary congestion, systemic congestion, or anginal syndrome at rest (e.g., recurrent or persistent fatigue, dyspnea, orthopnea, anginal discomfort);

OR

B. Documented cardiac enlargement by appropriate imaging techniques (see 4.02A) or ventricular dysfunction manifested by S3, abnormal wall motion, or left ventricular ejection fraction of 30 percent or less by appropriate imaging techniques; and

1. Inability to perform on an exercise test at a workload equivalent to 5 METs or less due to symptoms of chronic heart failure, or, in rare instances, a need to stop exercise testing at less than this level of work because of:

a. Three or more consecutive ventricular premature beats or three or more multiform beats; or

b. Failure to increase systolic blood pressure by 10 mmHg, or decrease in systolic pressure below the usual resting level (see 4.00C2b); or

c. Signs attributable to inadequate cerebral perfusion, such as ataxic gait or mental confusion; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Cor pulmonale fulfilling the criteria in 4.02A or B.

4.03 *Hypertensive cardiovascular disease.* Evaluate under 4.02 or 4.04, or under the criteria for the affected body system (2.02 through 2.04, 6.02, or 11.04A or B).

4.04 *Ischemic heart disease,* with chest discomfort associated with myocardial ischemia, as described in 4.00E3, while on a regimen of prescribed treatment (see 4.00A if there is no regimen of prescribed treatment). With one of the following:

A. Sign- or symptom-limited exercise test demonstrating at least one of the following manifestations at a workload equivalent to 5 METs or less:

1. Horizontal or downsloping depression, in the absence of digitalis glycoside therapy and/or hypokalemia, of the ST segment of at least −0.10 millivolts (−1.0 mm) in at least 3 consecutive complexes that are on a level baseline in any lead (other than aVR) and that have a typical ischemic time course of development and resolution (progression of horizontal or downsloping ST depression with exercise, and persistence of depression of at least −0.10 millivolts for at least 1 minute of recovery); or

2. An upsloping ST junction depression, in the absence of digitalis glycoside therapy and/or hypokalemia, in any lead (except aVR) of at least −0.2 millivolts or more for at least 0.08 seconds after the J junction and persisting for at least 1 minute of recovery; or

3. At least 0.1 millivolt (1 mm) ST elevation above resting baseline during both exercise and 3 or more minutes of recovery in ECG leads with low R and T waves in the leads demonstrating the ST segment displacement; or

4. Failure to increase systolic pressure by 10 mmHg, or decrease in systolic pressure below usual clinical resting level (see 4.00C2b); or

5. Documented reversible radionuclide ''perfusion'' (thallium^{201}) defect at an exercise level equivalent to 5 METs or less;

OR

B. Impaired myocardial function, documented by evidence (as outlined under 4.00C3 or 4.00C4b) of hypokinetic, akinetic, or dyskinetic myocardial free wall or septal wall motion with left ventricular ejection

fraction of 30 percent or less, and an evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, and resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest;

OR

C. Coronary artery disease, demonstrated by angiography (obtained independent of Social Security disability evaluation), and an evaluating program physician, preferably one experienced in the care of patients with cardiovascular disease, has concluded that performance of exercise testing would present a significant risk to the individual, with both 1 and 2:

1. Angiographic evidence revealing:

a. 50 percent or more narrowing of a nonbypassed left main coronary artery; or

b. 70 percent or more narrowing of another nonbypassed coronary artery; or

c. 50 percent or more narrowing involving a long (greater than 1 cm) segment of a nonbypassed coronary artery; or

d. 50 percent or more narrowing of at least 2 nonbypassed coronary arteries; or

e. Total obstruction of a bypass graft vessel; and

2. Resulting in marked limitation of physical activity, as demonstrated by fatigue, palpitation, dyspnea, or anginal discomfort on ordinary physical activity, even though the individual is comfortable at rest.

4.05 *Recurrent arrhythmias,* not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment (see 4.00A if there is no prescribed treatment), documented by resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

4.06 *Symptomatic congenital heart disease* (cyanotic or acyanotic), documented by appropriate imaging techniques (as outlined under 4.00C3) or cardiac catheterization. With one of the following:

A. Cyanosis at rest, and:

1. Hematocrit of 55 percent or greater, or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting arterial PO_2 of 60 Torr or less;

OR

B. Intermittent right-to-left shunting resulting in cyanosis on exertion (e.g., Eisenmenger's physiology) and with arterial PO_2 of 60 Torr or less at a workload equivalent to 5 METs or less;

OR

C. Chronic heart failure with evidence of ventricular dysfunction, as described in 4.02;

OR

D. Recurrent arrhythmias as described in 4.05;

OR

E. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure.

4.07 *Valvular heart disease or other stenotic defects, or valvular regurgitation,* documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.08 *Cardiomyopathies,* documented by appropriate imaging techniques or cardiac catheterization. Evaluate under the criteria in 4.02, 4.04, 4.05, or 11.04.

4.09 *Cardiac transplantation.* Consider under a disability for 1 year following surgery; thereafter, reevaluate residual impairment under 4.02 to 4.08.

4.10 *Aneurysm of aorta or major branches,* due to any cause (e.g., atherosclerosis, cystic medial necrosis, Marfan syndrome, trauma), demonstrated by an appropriate imaging technique. With one of the following:

A. Acute or chronic dissection not controlled by prescribed medical or surgical treatment;

OR

B. Chronic heart failure as described under 4.02;

OR

C. Renal failure as described under 6.02;

OR

D. Neurological complications as described under 11.04.

4.11 *Chronic venous insufficiency* of a lower extremity. With incompetency or obstruction of the deep venous system and one of the following:

A. Extensive brawny edema;

OR

B. Superficial varicosities, stasis dermatitis, and recurrent or persistent ulceration which has not healed following at least 3 months of prescribed medical or surgical therapy.

4.12 *Peripheral arterial disease.* With one of the following:

A. Intermittent claudication with failure to visualize (on arteriogram obtained independent of Social Security disability evaluation) the common femoral or deep femoral artery in one extremity;

OR

B. Intermittent claudication with marked impairment of peripheral arterial circulation as determined by Doppler studies showing:

1. Resting ankle/brachial systolic blood pressure ratio of less than 0.50; or

2. Decrease in systolic blood pressure at the ankle on exercise (see 4.00E4) of 50 percent or more of pre-exercise level at the ankle, and requiring 10 minutes or more to return to pre-exercise level;

OR

C. Amputation at or above the tarsal region due to peripheral vascular disease.

5.00 DIGESTIVE SYSTEM

A. *Disorders of the digestive system* which result in a marked impairment usually do so because of interference with nutrition, multiple recurrent inflammatory lesions, or complications of disease, such as fistulae, abscesses, or recurrent obstruction. Such complications usually respond to treatment. These complications must be shown to persist on repeated examinations despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months.

B. *Malnutrition or weight loss from gastrointestinal disorders.* When the primary disorder of the digestive tract has been established (e.g. enterocolitis, chronic pancreatitis, postgastrointestinal resection, or esophageal stricture, stenosis, or obstruction), the resultant interference with nutrition will be considered under the criteria in 5.08. This will apply whether the weight loss is due to primary or secondary disorders of malabsorption, malassimilation or obstruction. However, weight loss not due to diseases of the digestive tract, but associated with psychiatric or primary endocrine or other disorders, should be evaluated under the appropriate criteria for the underlying disorder.

C. *Surgical diversion of the intestinal tract,* including colostomy or ileostomy, are not listed since they do not represent impairments which preclude all work activity if the individual is able to maintain adequate nutrition and function of the stoma. Dumping syndrome which may follow gastric resection rarely represents a marked impairment which would continue for 12 months. Peptic ulcer disease with recurrent ulceration after definitive surgery ordinarily responds to treatment. A recurrent ulcer after definitive surgery must be demonstrated on repeated upper gastrointestinal roentgenograms or gastroscopic examinations despite therapy to be considered a severe impairmentich will last for at least 12 months. Definitive surgical procedures are those designed to control the ulcer disease process (i.e., vagotomy and pyloroplasty, subtotal gastrectomy, etc.). Simple closure of a perforated ulcer does not constitute definitive surgical therapy for peptic ulcer disease.

5.01 Category of Impairments, Digestive System

5.02 *Recurrent upper gastrointestinal hemorrhage from undetermined cause* with anemia manifested by hematocrit of 30 percent or less on repeated examinations.

5.03 *Stricture, stenosis, or obstruction of the esophagus (demonstrated by X-ray or endoscopy)* with weight loss as described under §5.08.

5.04 *Peptic ulcer disease (demonstrated by X-ray or endoscopy).* With:

A. Recurrent ulceration after definitive surgery persistent despite therapy; or

B. Inoperable fistula formation; or

C. Recurrent obstruction demonstrated by X-ray or endoscopy. or

D. Weight loss as described under §5.08.

5.05 *Chronic liver disease (e.g., portal, postnecrotic, or biliary cirrhosis; chronic active hepatitis; Wilson's disease).* With:

A. Esophageal varices (demonstrated by X-ray or endoscopy) with a documented history of massive hemorrhage attributable to these varices. Consider under a disability for 3 years following the last massive hemorrhage; thereafter, evaluate the residual impairment; or

B. Performance of a shunt operation for esophageal varices. Consider under a disability for 3 years following surgery; thereafter, evaluate the residual impairment; or

C. Serum bilirubin of 2.5 mg. per deciliter (100 ml.) or greater persisting on repeated examinations for at least 5 months; or

D. Ascites, not attributable to other causes, recurrent or persisting for at least 5 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

E. Hepatic encephalopathy. Evaluate under the criteria in listing 12.02; or

F. Confirmation of chronic liver disease by liver biopsy (obtained independent of Social Security disability evaluation) and one of the following:

1. Ascites not attributable to other causes, recurrent or persisting for at least 3 months, demonstrated by abdominal paracentesis or associated with persistent hypoalbuminemia of 3.0 gm. per deciliter (100 ml.) or less; or

2. Serum bilirubin of 2.5 mg. per deciliter (100 ml) or greater on repeated examinations for at least 3 months; or

3. Hepatic cell necrosis or inflammation, persisting for at least 3 months, documented by repeated abnormalities of prothrombin time and enzymes indicative of hepatic dysfunction.

5.06 *Chronic ulcerative or granulomatous colitis (demonstrated by endoscopy, barium enema, biopsy, or operative findings).* With:

A. Recurrent bloody stools documented on repeated examinations and anemia manifested by hematocrit of 30 percent or less on repeated examinations; or

B. Persistent or recurrent systemic manifestations, such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess, fistula formation, or stenosis; or

D. Recurrence of findings of A, B, or C above after total colectomy; or

E. Weight loss as described under §5.08.

5.07 *Regional enteritis (demonstrated by operative findings, barium studies, biopsy, or endoscopy).* With:

A. Persistent or recurrent intestinal obstruction evidenced by abdominal pain, distention, nausea, and vomiting and accompanied by stenotic areas of small bowel with proximal intestinal dilation; or

B. Persistent or recurrent systemic manifestations such as arthritis, iritis, fever, or liver dysfunction, not attributable to other causes; or

C. Intermittent obstruction due to intractable abscess or fistula formation; or

D. Weight loss as described under §5.08.

5.08 *Weight loss due to any persisting gastrointestinal disorder:* (The following weights are to be demonstrated to have persisted for at least 3 months despite prescribed therapy and expected to persist at this level for at least 12 months.) With:

A. Weight equal to or less than the values specified in table I or II; or

B. Weight equal to or less than the values specified in table III or IV and one of the following abnormal findings on repeated examinations:

1. Serum albumin of 3.0 gm. per deciliter (100 ml.) or less; or

2. Hematocrit of 30 percent or less; or

3. Serum calcium of 8.0 mg. per deciliter (100 ml.) (4.0 mEq./L) or less; or

4. Uncontrolled diabetes mellitus due to pancreatic dysfunction with repeated hyperglycemia, hypoglycemia, or ketosis; or

5. Fat in stool of 7 gm. or greater per 24-hour stool specimen; or

6. Nitrogen in stool of 3 gm, or greater per 24-hour specimen; or

7. Persistent or recurrent ascites or edema not attributable to other causes.

Tables of weight reflecting malnutrition scaled according to height and sex—To be used only in connection with 5.08.

TABLE I—MEN

Height (inches) [1]	Weight (pounds)
61	90
62	92
63	94
64	97
65	99
66	102
67	106
68	109
69	112
70	115
71	118
72	122
73	125

TABLE I—MEN—Continued

Height (inches) [1]	Weight (pounds)
74	128
75	131
76	134

[1] Height measured without shoes.

TABLE II—WOMEN

Height (inches) [1]	Weight (pounds)
58	77
59	79
60	82
61	84
62	86
63	89
64	91
65	94
66	98
67	101
68	104
69	107
70	110
71	114
72	117
73	120

[1] Height measured without shoes.

TABLE III—MEN

Height (inches) [1]	Weight (pounds)
61	95
62	98
63	100
64	103
65	106
66	109
67	112
68	116
69	119
70	122
71	126
72	129
73	133
74	136
75	139
76	143

[1] Height measured without shoes.

TABLE IV—WOMEN

Height (inches) [1]	Weight (pounds)
58	82
59	84
60	87
61	89
62	92
63	94
64	97
65	100
66	104
67	107
68	111
69	114
70	117

TABLE IV—WOMEN—Continued

Height (inches) [1]	Weight (pounds)
71	121
72	124
73	128

[1] Height measured without shoes.

6.00 GENITO-URINARY SYSTEM

A. *Determination of the presence of chronic renal disease will be based upon* (1) a history, physical examination, and laboratory evidence of renal disease, and (2) indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Nephrotic Syndrome.* The medical evidence establishing the clinical diagnosis must include the description of extent of tissue edema, including pretibial, periorbital, or presacral edema. The presence of ascites, pleural effusion, pericardial effusion, and hydroarthrosis should be described if present. Results of pertinent laboratory tests must be provided. If a renal biopsy has been performed, the evidence should include a copy of the report of microscopic examination of the specimen. Complications such as severe orthostatic hypotension, recurrent infections or venous thromboses should be evaluated on the basis of resultant impairment.

C. *Hemodialysis, peritioneal dialysis, and kidney transplantation.* When an individual is undergoing periodic dialysis because of chronic renal disease, severity of impairment is reflected by the renal function prior to the institution of dialysis.

The amount of function restored and the time required to effect improvement in an individual treated by renal transplant depend upon various factors, including adequacy of post transplant renal function, incidence and severity of renal infection, occurrence of rejection crisis, the presence of systemic complications (anemia, neunropathy, etc.) and side effects of corticosteroids or immuno-suppressive agents. A convalesent period of at least 12 months is required before it can be reasonably determined whether the individual has reached a point of stable medical improvement.

D. *Evaluate associated disorders and complications* according to the appropriate body system Listing.

6.01 Category of Impairments, Genito-Urinary System

6.02 Impairment of renal function, due to any chronic renal disease expected to last 12 months (e.g., hypertensive vascular disease, chronic nephritis, nephrolithiasis, polycystic disease, bilateral hydronephrosis, etc.) With:

A. Chronic hemodialysis or peritoneal dialysis necessitated by irreversible renal failure; or

B. Kidney transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 6.00C); or

C. Persistent elevation of serum creatine in to 4 mg. per deciliter (100 ml.) or greater or reduction of creatinine clearance to 20 ml. per minute (29 liters/24 hours) or less, over at least 3 months, with one of the following:

1. Renal osteodystrophy manifested by severe bone pain and appropriate radiographic abnormalities (e.g., osteitis fibrosa, marked osteoporosis, pathologic fractures); or

2. A clinical episode of pericarditis; or

3. Persistent motor or sensory neuropathy; or

4. Intractable pruritus; or

5. Persistent fluid overload syndrome resulting in diastolic hypertension (110 mm. or above) or signs of vascular congestion; or

6. Persistent anorexia with recent weight loss and current weight meeting the values in 5.08, table III or IV; or

7. Persistent hematocrits of 30 percent or less.

6.06 *Nephrotic syndrome, with significant anasarca, persistent for at least 3 months despite prescribed therapy.* With:

A. Serum albumin of 3.0 gm. per deciler (100 ml.) or less *and* protenuria of 3.5 gm. per 24 hours or greater; or

B. Proteinuria of 10.0 gm. per 24 hours or greater.

7.00 HEMIC AND LYMPHATIC SYSTEM

A. *Impairment caused by anemia* should be evaluated according to the ability of the individual to adjust to the reduced oxygen carrying capacity of the blood. A gradual reduction in red cell mass, even to very low values, is often well tolerated in individuals with a healthy cardiovascular system.

B. *Chronicity is indicated by* persistence of the condition for at least 3 months. The laboratory findings cited must reflect the values reported on more than one examination over that 3-month period.

C. *Sickle cell disease* refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis, must be included. Vasoocclusive or aplastic episodes should be documented by description of severity, frequency, and duration.

Major visceral episodes include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genito-urinary involvement, etc.

D. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence. Prophylactic therapy such as with antihemophilic

globulin (AHG) concentrate does not in itself imply severity.

E. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The acute phase of chronic myelocytic (granulocytic) leukemia should be considered under the requirements for acute leukemia.

The criteria in 7.11 contain the designated duration of disability implicit in the finding of a listed impairment. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a marked impairment. The level of any remaining impairment must be evaluated on the basis of the medical evidence.

7.01 Category of Impairments, Hemic and Lymphatic System

7.02 *Chronic anemia (hematocrit persisting at 30 percent or less due to any cause).* With:

A. Requirement of one or more blood transfusions on an average of at least once every 2 months; or

B. Evaluation of the resulting impairment under criteria for the affected body system.

7.05 *Sickle cell disease, or one of its variants.* With:

A. Documented painful (thrombotic) crises occurring at least three times during the 5 months prior to adjudication; or

B. Requiring extended hospitalization (beyond emergency care) at least three times during the 12 months prior to adjudication; or

C. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

D. Evaluate the resulting impairment under the criteria for the affected body system.

7.06 *Chronic thrombocytopenia (due to any cause)* with platelet counts repeatedly below 40,000/cubic millimeter. With:

A. At least one spontaneous hemorrhage, requiring transfusion, within 5 months prior to adjudication; or

B. Intracranial bleeding within 12 months prior to adjudication.

7.07 *Hereditary telangiectasia* with hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.08 *Coagulation defects (hemophilia or a similar disorder)* with spontaneous hemorrhage requiring transfusion at least three times during the 5 months prior to adjudication.

7.09 *Polycythemia vera (with erythrocytosis, splenomegaly, and leukocytosis or thrombocytosis).* Evaluate the resulting impairment under the criteria for the affected body system.

7.10 *Myelofibrosis (myeloproliferative syndrome).* With:

A. Chronic anemia. Evaluate according to the criteria of §7.02; or

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication; or

C. Intractable bone pain with radiologic evidence of osteosclerosis.

7.11 *Acute leukemia.* Consider under a disability for 2½ years from the time of initial diagnosis.

7.12 *Chronic leukemia.* Evaluate according to the criteria of 7.02, 7.06, 7.10B, 7.11, 7.17, or 13.06A.

7.13 *Lymphomas.* Evaluate under the criteria in 13.06A.

7.14 *Macroglobulinemia or heavy chain disease,* confirmed by serum or urine protein electrophoresis or immunoelectrophoresias. Evaluate impairment under criteria for affected body system or under 7.02, 7.06, or 7.08.

7.15 *Chronic granulocytopenia (due to any cause).* With both A and B:

A. Absolute neutrophil counts repeatedly below 1,000 cells/cubic millimeter; and

B. Documented recurrent systemic bacterial infections occurring at least 3 times during the 5 months prior to adjudication.

7.16 *Myeloma (confirmed by appropriate serum or urine protein electrophoresis and bone marrow findings).* With:

A. Radiologic evidence of bony involvement with intractable bone pain; or

B. Evidence of renal impairment as described in 6.02; or

C. Hypercalcemia with serum calcium levels persistently greater than 11 mg. per deciliter (100 ml.) for at least 1 month despite prescribed therapy; or

D. Plasma cells (100 or more cells/cubic millimeter) in the peripheral blood.

7.17 *Aplastic anemias or hematologic malignancies (excluding acute leukemia):* With bone marrow transplantation. Consider under a disability for 12 months following transplantation; thereafter, evaluate according to the primary characteristics of the residual impairment.

8.00 SKIN

A. *Skin lesions* may result in a marked, long-lasting impairment if they involve extensive body areas or critical areas such as the hands or feet and become resistant to treatment. These lesions must be shown to have persisted for a sufficient period of time despite therapy for a reasonable presumption to be made that a marked impairment will last for a continuous period of at least 12 months. The treatment for some of the skin diseases listed in this section may require the use of high dosage of drugs with possible serious side effects; these side effects should be considered in the overall evaluation of impairment.

B. *When skin lesions are associated with systemic disease* and where that is the predominant problems, evaluation should occur according to the criteria in the appropriate section. Disseminated (systemic) lupus erythematosus and scleroderma usually involve more than one body system and should be evaluated under 14.02 and 14.04. Neoplastic skin lesions should be evaluated under 13.00ff. When skin lesions (including burns) are associated with contractures or limitation of joint motion, that impairment should be evaluated under 1.00ff.

8.01 Category of Impairments, Skin

8.02 *Exfoliative dermatitis, ichthyosis, ichthyosiform erythroderma.* With extensive lesions not responding to prescribed treatment.

8.03 *Pemphigus, erythema multiforme bullosum, bullous pemphigoid, dermatitis herpetiformis.* With extensive lesions not responding to prescribed treatment.

8.04 *Deep mycotic infections. With extensive fungating, ulcerating lesions not responding to prescribed treatment.*

8.05 *Psoriasis, atopic dermatitis, dyshidrosis.* With extensive lesions, including involvement of the hands or feet which impose a marked limitation of function and which are not responding to prescribed treatment.

8.06 *Hydradenitis suppurative, acne conglobata.* With extensive lesions involving the axillae or perineum not responding to prescribed medical treatment and not amendable to surgical treatment.

9.00 Endocrine System

Cause of impairment. Impairment is caused by overproduction or underproduction of hormones, resulting in structural or functional changes in the body. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

9.01 *Category of Impairments, Endocrine System*

9.02 *Thyroid Disorders.* With:

A. Progressive exophthalmos as measured by exophthalmometry; or

B. Evaluate the resulting impairment under the criteria for the affected body system.

9.03 *Hyperparathyroidism.* With:

A. Generalized decalcification of bone on X-ray study and elevation of plasma calcium to 11 mg. per deciliter (100 ml.) or greater; or

B. A resulting impairment. Evaluate according to the criteria in the affected body system.

9.04 *Hypoparathyroidism.* With:

A. Severe recurrent tetany; or

B. Recurrent generalized convulsions; or

C. Lenticular cataracts. Evaluate under the criteria in 2.00ff.

9.05 *Neurohypophyseal insufficiency (diabetes insipidus).* With urine specific gravity of 1.005 or below, persistent for at least 3 months and recurrent dehydration.

9.06 *Hyperfunction of the adrenal cortex.* Evaluate the resulting impairment under the criteria for the affected body system.

9.08 *Diabetes mellitus.* With:

A. Neuropathy demonstrated by significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C); or

B. Acidosis occurring at least on the average of once every 2 months documented by appropriate blood chemical tests (pH or PCO_2 or bicarbonate levels); or

C. Amputation at, or above, the tarsal region due to diabetic necrosis or peripheral arterial disease; or

D. Retinitis proliferans; evaluate the visual impairment under the criteria in 2.02, 2.03, or 2.04.

TABLE I—MEN

[Metric]

Height without shoes (centimeters)	Weight (kilograms)
152	112
155	115
157	117
160	120
163	123
165	125
168	129
170	134
173	137
175	141
178	145
180	149
183	153
185	157
188	162
190	165
193	170

TABLE I—MEN

Height without shoes (inches)	Weight (pounds)
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

TABLE II—WOMEN

[Metric]

Height without shoes (centimeters)	Weight (kilograms)
142	95
145	96
147	99
150	102
152	105
155	107
157	110
160	114
163	117
165	121
168	125
170	128
173	132
175	135
178	139
180	143
183	146

TABLE II—WOMEN

Height without shoes (inches)	Weight (pounds)
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

TABLE III—A

[Applicable at test sites less than 3,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

TABLE III—B

[Applicable at test sites 3,000 through 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

TABLE III—C

[Applicable at test sites over 6,000 feet above sea level]

Arterial PCO_2 (mm. Hg) and	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

10.00 [RESERVED]

11.00 NEUROLOGICAL

A. *Convulsive disorders.* In convulsive disorders, regardless of etiology degree of impairment will be determined according to type, frequency, duration, and sequelae of seizures. At least one detailed description of a typical seizure is required. Such description includes the presence or absence of aura, tongue bites, sphincter control, injuries associated with the attack, and postictal phenomena. The reporting physician should indicate the extent to which description of seizures reflects his own observations and the source of ancillary information. Testimony of persons other than the claimant is essential for description of type and frequency of seizures if professional observation is not available.

Documentation of epilepsy should include at least one electroencephalogram (EEG).

Under 11.02 and 11.03, the criteria can be applied only if the impairment persists despite the fact that the individual is following prescribed anticonvulsive treatment. Adherence to prescribed anticonvulsive therapy

can ordinarily be determined from objective clinical findings in the report of the physician currently providing treatment for epilepsy. Determination of blood levels of phenytoin sodium or other anticonvulsive drugs may serve to indicate whether the prescribed medication is being taken. When seizures are occurrring at the frequency stated in 11.02 or 11.03, evalution of the severity of the impairment must include consideration of the serum drug levels. Should serum drug levels appear therapeutically inadequate, consideration should be given as to whether this is caused by individual idiosyncrasy in absorption of metabolism of the drug. Blood drug levels should be evaluated in conjunction with all the other evidence to determine the extent of compliance. When the reported blood drug levels are low, therefore, the information obtained from the treating source should include the physician's statement as to why the levels are low and the results of any relevant diagnostic studies concerning the blood levels. Where adequate seizure control is obtained only with unusually large doses, the possibility of impairment resulting from the side effects of this medication must be also assessed. Where documentation shows that use of alcohol or drugs affects adherence to prescribed therapy or may play a part in the precipitation of seizures, this must also be considered in the overall assessment of impairment level.

B. *Brain tumors.* The diagnosis of malignant brain tumors must be established, and the persistence of the tumor should be evaluated, under the criteria described in 13.00B and C for neoplastic disease.

In histologically malignant tumors, the pathological diagnosis alone will be the decisive criterion for severity and expected duration (see 11.05A). For other tumors of the brain, the severity and duration of the impairment will be determined on the basis of symptoms, signs, and pertinent laboratory findings (11.05B).

C. *Persistent disorganization of motor function* in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory distrubances (any or all of which may be due to cerebral cerbellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combination, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands, and arms.

D. *In conditions which are episodic in character,* such as multiple sclerosis or myasthenia gravis, consideration should be given to frequency and duration of exacerbations, length of remissions, and permanent residuals.

E. *Multiple sclerosis.* The major criteria for evaluating impairment caused by multiple sclerosis are discussed in listing 11.09. Paragraph A provides criteria for evaluating disorganization of motor function and gives reference to 11.04B (11.04B then refers to 11.00C). Paragraph B provides references to other listings for evaluating visual or mental impairments caused by multiple sclerosis. Paragraph C provides criteria for evaluating the impairment of individuals who do not have muscle weakness or other significant disorganization of motor function at rest, but who do develop muscle weakness on activity as a result of fatigue.

Use of the criteria in 11.09C is dependent upon (1) documenting a diagnosis of multiple sclerosis, (2) obtaining a description of fatigue considered to be characteristic of multiple sclerosis, and (3) obtaining evidence that the system has actually become fatigued. The evaluation of the magnitude of the impairment must consider the degree of exercise and the severity of the resulting muscle weakness.

The criteria in 11.09C deals with motor abnormalities which occur on activity. If the disorganization of motor function is present at rest, paragraph A must be used, taking into account any further increase in muscle weakness resulting from activity.

Sensory abnormalities may occur, particularly involving central visual acuity. The decrease in visual acuity may occur after brief attempts at activity involving near vision, such as reading. This decrease in visual acuity may not persist when the specific activity is terminated, as with rest, but is predictably reproduced with resumption of the activity. The impairment of central visual acuity in these cases should be evaluated under the criteria in listing 2.02, taking into account the fact that the decrease in visual acuity will wax and wane.

Clarification of the evidence regarding central nervous system dysfunction responsible for the symptoms may require supporting technical evidence of functional impairment such as evoked response tests during exercise.

11.01 Category of Impairments, Neurological

11.02 *Epilepsy—major motor seizures, (grand mal or psychomotor), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once a month, in spite of at least 3 months of prescribed treatment.* With:

A. Daytime episodes (loss of consciousness and convulsive seizures) or

B. Nocturnal episodes manifesting residuals which interfere significantly with activity during the day.

11.03 *Epilepsy—Minor motor seizures (petit mal, psychomotor, or focal), documented by EEG and by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once*

weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.

11.04 *Central nervous system vascular accident.* With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.05 *Brain tumors.*

A. Malignant gliomas (astrocytoma—grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, or primary sarcoma; or

B. Astrocytoma (grades I and II), meningioma, pituitary tumors, oligodendroglioma, ependymoma, clivus chordoma, and benign tumors. Evaluate under 11.02, 11.03, 11.04 A, or B, or 12.02.

11.06 *Parkinsonian syndrome* with the following signs: Significant rigidity, brady kinesia, or tremor in two extremities, which, singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

11.07 *Cerebral palsy*. With:

A. IQ of 70 or less; or

B. Abnormal behavior patterns, such as destructiveness or emotional instability: or

C. Significant interference in communication due to speech, hearing, or visual defect; or

D. Disorganization of motor function as described in 11.04B.

11.08 *Spinal cord or nerve root lesions, due to any cause* with disorganization of motor function as described in 11.04B.

11.09 *Multiple sclerosis.* With:

A. Disorganization of motor function as described in 11.04B; or

B. Visual or mental impairment as described under the criteria in 2.02, 2.03, 2.04, or 12.02; or

C. Significant, reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process.

11.10 *Amyotrophic lateral sclerosis. With:*

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

11.11 *Anterior poliomyelitis.* With:

A. Persistent difficulty with swallowing or breathing; or

B. Unintelligible speech; or

C. Disorganization of motor function as described in 11.04B.

11.12 *Myasthenia gravis.* With:

A. Significant difficulty with speaking, swallowing, or breathing while on prescribed therapy; or

B. Significant motor weakness of muscles of extremities on repetitive activity against resistance while on prescribed therapy.

11.13 *Muscular dystrophy* with disorganization of motor function as described in 11.04B.

11.14 *Peripheral neuropathies.*

With disorganization of motor function as described in 11.04B, in spite of prescribed treatment.

11.15 *Tabes dorsalis.*

With:

A. Tabetic crises occurring more frequently than once monthly; or

B. Unsteady, broad-based or ataxic gait causing significant restriction of mobility substantiated by appropriate posterior column signs.

11.16 *Subacute combined cord degeneration (pernicious anemia) with disorganization of motor function as decribed in 11.04B or 11.15B, not significantly improved by prescribed treatment.*

11.17 *Degenerative disease not elsewhere such as Huntington's chorea, Friedreich's ataxia, and spino-cerebellar degeneration*. With:

A. Disorganization of motor function as described in 11.04B or 11.15B; or

B. Chronic brain syndrome. Evaluate under 12.02.

11.18 *Cerebral trauma:*

Evaluate under the provisions of 11.02, 11.03, 11.04 and 12.02, as applicable.

11.19 *Syringomyelia.*

With:

A. Significant bulbar signs; or

B. Disorganization of motor function as described in 11.04B.

12.00 Mental Disorders

The mental disorders listings in 12.00 of the Listing of Impairments will no longer be effective on August 28, 1997, unless extended by the Commissioner or revised and promulgated again.

A. *Introduction:* The evaluation of disability on the basis of mental disorders requires the documentation of a medically determinable impairment(s) as well as consideration of the degree of limitation such impairment(s) may impose on the individual's ability to work and whether these limitations have lasted or are expected to last for a continuous period of at least 12 months. The listings for mental disorders are arranged in eight diagnostic categories: organic mental disorders (12.02); schizophrenic, paranoid and other psychotic disorders (12.03); affective disorders (12.04); mental retardation and autism (12.05); anxiety related disorders (12.06); somatoform disorders

(12.07); personality disorders (12.08); and substance addiction disorders (12.09). Each diagnostic group, except listings 12.05 and 12.09, consists of a set of clinical findings (paragraph A criteria), one or more of which must be met, and which, if met, lead to a test of functional restrictions (paragraph B criteria), two or three of which must also be met. There are additional considerations (paragraph C criteria) in listings 12.03 and 12.06, discussed therein.

The purpose of including the criteria in paragraph A of the listings for mental disorders is to medically substantiate the presence of a mental disorder. Specific signs and symptoms under any of the listings 12.02 through 12.09 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) which is supported by the individual's clinical findings.

The purpose of including the criteria in paragraphs B and C of the listings for mental disorders is to describe those functional limitations associated with mental disorders which are incompatible with the ability to work. The restrictions listed in paragraphs B and C must be the result of the mental disorder which is manifested by the clinical findings outlined in paragraph A. The criteria included in paragraphs B and C of the listings for mental disorders have been chosen because they represent functional areas deemed essential to work. An individual who is severely limited in these areas as the result of an impairment identified in paragraph A is presumed to be unable to work.

The structure of the listing for substance addiction disorders, listing 12.09, is different from that for the other mental disorder listings. Listing 12.09 is structured as a reference listing; that is, it will only serve to indicate which of the other listed mental or physical impairments must be used to evaluate the behavioral or physical changes resulting from regular use of addictive substances.

The listings for mental disorders are so constructed that an individual meeting or equaling the criteria could not reasonably be expected to engage in gainful work activity.

Individuals who have an impairment with a level of severity which does not meet the criteria of the listings for mental disorders may or may not have the residual functional capacity (RFC) which would enable them to engage in substantial gainful work activity. The determination of mental RFC is crucial to the evaluation of an individual's capacity to engage in substantial gainful work activity when the criteria of the listings for mental disorders are not met or equaled but the impairment is nevertheless severe.

RFC may be defined as a multidimensional description of the work-related abilities which an individual retains in spite of medical impairments. RFC complements the criteria in paragraphs B and C of the listings for mental disorders by requiring consideration of an expanded list of work-related capacities which may be impaired by mental disorder when the impairment is severe but does not meet or equal a listed mental disorder.

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of clinical signs, symptoms and/or laboratory or psychological test findings. These findings may be intermittent or persistent depending on the nature of the disorder. Clinical signs are medically demonstrable phenomena which reflect specific abnormalities of behavior, affect, thought, memory, orientation, or contact with reality. These signs are typically assessed by a psychiatrist or psychologist and/or documented by psychological tests. Symptoms are complaints presented by the individual. Signs and symptoms generally cluster together to constitute recognizable clinical syndromes (mental disorders). Both symptoms and signs which are part of any diagnosed mental disorder must be considered in evaluating severity.

C. *Assessment of Severity:* For mental disorders, severity is assessed in terms of the functional limitations imposed by the impairment. Functional limitations are assessed using the criteria in paragraph B of the listings for mental disorders (descriptions of restrictions of activities of daily living; social functioning; concentration, persistence, or pace; and ability to tolerate increased mental demands associated with competitive work). Where ''marked'' is used as a standard for measuring the degree of limitation, it means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Four areas are considered.

1. *Activities of daily living* include adaptive activities such as cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc. In the context of the individual's overall situation, the quality of these activities is judged by their independence, appropriateness and effectiveness. It is necessary to define the extent to which the individual is capable of initiating and participating in activities independent of supervision or direction.

''Marked'' is not the number of activities which are restricted but the overall degree of

restriction or combination of restrictions which must be judged. For example, a person who is able to cook and clean might still have marked restrictions of daily activities if the person were too fearful to leave the immediate environment of home and neighborhood, hampering the person's ability to obtain treatment or to travel away from the immediate living environment.

2. *Social functioning* refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. Social functioning includes the ability to get along with others, e.g., family members, friends, neighbors, grocery clerks, landlords, bus drivers, etc. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strength in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity also need to be considered. Social functioning in work situations may involve interactions with the public, responding appropriately to persons in authority, e.g., supervisors, or cooperative behaviors involving coworkers.

''Marked'' is not the number of areas in which social functioning is impaired, but the overall degree of interference in a particular area or combination of areas of functioning. For example, a person who is highly antagonistic, uncooperative or hostile but is tolerated by local storekeepers may nevertheless have marked restrictions in social functioning because that behavior is not acceptable in other social contexts.

3. *Concentration, persistence and pace* refer to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work and work-like settings. Major impairment in this area can often be assessed through direct psychiatric examination and/or psychological testing, although mental status examination or psychological test data alone should not be used to accurately describe concentration and sustained ability to adequately perform work-like tasks. On mental status examinations, concentration is assessed by tasks such as having the individual subtract serial sevens from 100. In psychological tests of intelligence or memory, concentration is assessed through tasks requiring short-term memory or through tasks that must be completed within established time limits. In work evaluations, concentration, persistence, and pace are assessed through such tasks as filing index cards, locating telephone numbers, or disassembling and reassembling objects. Strengths and weaknesses in areas of concentration can be discussed in terms of frequency of errors, time it takes to complete the task, and extent to which assistance is required to complete the task.

4. *Deterioration or decompensation in work or work-like settings* refers to repeated failure to adapt to stressful circumstances which cause the individual either to withdraw from that situation or to experience exacerbation of signs and symptoms (i.e., decompensation) with an accompanying difficulty in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence, or pace (i.e., deterioration which may include deterioration of adaptive behaviors). Stresses common to the work environment include decisions, attendance, schedules, completing tasks, interactions with supervisors, interactions with peers, etc.

D. *Documentation:* The presence of a mental disorder should be documented primarily on the basis of reports from individual providers, such as psychiatrists and psychologists, and facilities such as hospitals and clinics. Adequate descriptions of functional limitations must be obtained from these or other sources which may include programs and facilities where the individual has been observed over a considerable period of time.

Information from both medical and nonmedical sources may be used to obtain detailed descriptions of the individual's activities of daily living; social functioning; concentration, persistance and pace; or ability to tolerate increased mental demands (stress). This information can be provided by programs such as community mental health centers, day care centers, sheltered workshops, etc. It can also be provided by others, including family members, who have knowledge of the individual's functioning. In some cases descriptions of activities of daily living or social functioning given by individuals or treating sources may be insufficiently detailed and/or may be in conflict with the clinical picture otherwise observed or described in the examinations or reports. It is necessary to resolve any inconsistencies or gaps that may exist in order to obtain a proper understanding of the individual's functional restrictions.

An individual's level of functioning may vary considerably over time. The level of functioning at a specific time may seem relatively adequate or, conversely, rather poor. Proper evaluation of the impairment must take any variations in level of functioning into account in arriving at a determination of impairment severity over time. Thus, it is vital to obtain evidence from relevant sources over a sufficiently long period prior

to the date of adjudication in order to establish the individual's impairment severity. This evidence should include treatment notes, hospital discharge summaries, and work evaluation or rehabilitation progress notes if these are available.

Some individuals may have attempted to work or may actually have worked during the period of time pertinent to the determination of disability. This may have been an independent attempt at work, or it may have been in conjunction with a community mental health or other sheltered program which may have been of either short or long duration. Information concerning the individual's behavior during any attempt to work and the circumstances surrounding termination of the work effort are particularly useful in determining the individual's ability or inability to function in a work setting.

The results of well-standardized psychological tests such as the Wechsler Adult Intelligence Scale (WAIS), the Minnesota Multiphasic Personality Inventory (MMPI), the Rorschach, and the Thematic Apperception Test (TAT), may be useful in establishing the existence of a mental disorder. For example, the WAIS is useful in establishing mental retardation, and the MMPI, Rorschach, and TAT may provide data supporting several other diagnoses. Broad-based neuropsychological assessments using, for example, the Halstead-Reitan or the Luria-Nebraska batteries may be useful in determining brain function deficiencies, particularly in cases involving subtle findings such as may be seen in traumatic brain injury. In addition, the process of taking a standardized test requires concentration, persistence and pace; performance on such tests may provide useful data. Test results should, therefore, include both the objective data and a narrative description of clinical findings. Narrative reports of intellectual assessment should include a discussion of whether or not obtained IQ scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

In cases involving impaired intellectual functioning, a standardized intelligence test, e.g., the WAIS, should be administered and interpreted by a psychologist or psychiatrist qualified by training and experience to perform such an evaluation. In special circumstances, nonverbal measures, such as the Raven Progressive Matrices, the Leiter international scale, or the Arthur adaptation of the Leiter may be substituted.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. In this connection, it must be noted that on the WAIS, for example, IQs of 70 and below are characteristic of approximately the lowest 2 percent of the general population. In instances where other tests are administered, it would be necessary to convert the IQ to the corresponding percentile rank in the general population in order to determine the actual degree of impairment reflected by those IQ scores.

In cases where more than one IQ is customarily derived from the test administered, i.e., where verbal, performance, and full-scale IQs are provided as on the WAIS, the lowest of these is used in conjunction with listing 12.05.

In cases where the nature of the individual's intellectual impairment is such that standard intelligence tests, as described above, are precluded, medical reports specifically describing the level of intellectual, social, and physical function should be obtained. Actual observations by Social Security Administration or State agency personnel, reports from educational institutions and information furnished by public welfare agencies or other reliable objective sources should be considered as additional evidence.

E. *Chronic Mental Impairments:* Particular problems are often involved in evaluating mental impairments in individuals who have long histories of repeated hospitalizations or prolonged outpatient care with supportive therapy and medication. Individuals with chronic psychotic disorders commonly have their lives structured in such a way as to minimize stress and reduce their signs and symptoms. Such individuals may be much more impaired for work than their signs and symptoms would indicate. The results of a single examination may not adequately describe these individuals' sustained ability to function. It is, therefore, vital to review all pertinent information relative to the individual's condition, especially at times of increased stress. It is mandatory to attempt to obtain adequate descriptive information from all sources which have treated the individual either currently or in the time period relevant to the decision.

F. *Effects of Structured Settings:* Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, board and care facility, or other environment that provides similar structure. Highly structured and supportive settings may greatly reduce the mental demands placed on an individual. With lowered mental demands, overt signs and symptoms of the underlying mental disorder may be minimized. At the same time, however, the individual's ability to function outside of such a structured and/or supportive setting may not have changed. An evaluation of individuals whose symptomatology is controlled or attenuated by psychosocial factors must consider the ability of the individual to function outside of such highly structured settings. (For these reasons the paragraph C criteria were added to Listings 12.03 and 12.06.)

G. *Effects of Medication:* Attention must be given to the effect of medication on the individual's signs, symptoms and ability to function. While psychotropic medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the psychotropic medications, particular attention must be focused on the functional restrictions which may persist. These functional restrictions are also to be used as the measure of impairment severity. (See the paragraph C criteria in Listings 12.03 and 12.06.)

Neuroleptics, the medicines used in the treatment of some mental illnesses, may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity. Where adverse effects of medications contribute to the impairment severity and the impairment does not meet or equal the listings but is nonetheless severe, such adverse effects must be considered in the assessment of the mental residual functional capacity.

H. *Effect of Treatment:* It must be remembered that with adequate treatment some individuals suffering with chronic mental disorders not only have their symptoms and signs ameliorated but also return to a level of function close to that of their premorbid status. Our discussion here in 12.00H has been designed to reflect the fact that present day treatment of a mentally impaired individual may or may not assist in the achievement of an adequate level of adaptation required in the work place. (See the paragraph C criteria in Listings 12.03 and 12.06.)

I. *Technique for Reviewing the Evidence in Mental Disorders Claims to Determine Level of Impairment Severity:* A special technique has been developed to ensure that all evidence needed for the evaluation of impairment severity in claims involving mental impairment is obtained, considered and properly evaluated. This technique, which is used in connection with the sequential evaluation process, is explained in §404.1520a and §416.920a.

12.01 Category of Impairments-Mental

12.02 *Organic Mental Disorders:* Psychological or behaviorial abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or

2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or

4. Change in personality; or

5. Disturbance in mood; or

6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or

7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.03 *Schizophrenic, Paranoid and Other Psychotic Disorders:* Characterized by the onset of psychotic features with deterioration from a previous level of functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:

a. Blunt affect; or

b. Flat affect; or

c. Inappropriate affect;

or

4. Emotional withdrawal and/or isolation;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of this listing, although these symptoms or signs are currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from that situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors); or

2. Documented current history of two or more years of inability to function outside of a highly supportive living situation.

12.04 *Affective Disorders:* Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

a. Anhedonia or pervasive loss of interest in almost all activites; or

b. Appetite disturbance with change in weight; or

c. Sleep disturbance; or

d. Psychomotor agitation or retardation; or

e. Decreased energy; or

f. Feelings of guilt or worthlessness; or

g. Difficulty concentrating or thinking; or

h. Thoughts of suicide; or

i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

a. Hyperactivity; or

b. Pressure of speech; or

c. Flight of ideas; or

d. Inflated self-esteem; or

e. Decreased need for sleep; or

f. Easy distractability; or

g. Involvement in activities that have a high probability of painful consequences which are not recognized; or

h. Hallucinations, delusions or paranoid thinking;

or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.05 *Mental Retardation and Autism:* Mental retardation refers to a significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22). (Note: The scores specified below refer to those obtained on the WAIS, and are used only for reference purposes. Scores obtained on other standardized and individually administered tests are acceptable, but the numerical values obtained must indicate a similar level of intellectual functioning.) Autism is a pervasive developmental disorder characterized by social and significant communication deficits originating in the developmental period.

The required level of severity for this disorder is met when the requirements in A, B, C, or D are satisfied.

A. Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing, or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded;

OR

B. A valid verbal, performance, or full scale IQ of 59 or less;

OR

C. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant work-related limitation of function;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70, or in the case of autism, gross deficits of social and communicative skills, with either condition resulting in two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.06 *Anxiety Related Disorders:* In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied.

A. Medically documented findings of at least one of the following:

1. Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

a. Motor tension; or

b. Autonomic hyperactivity; or

c. Apprehensive expectation; or

d. Vigilance and scanning;

or

2. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3. Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4. Recurrent obsessions or compulsions which are a source of marked distress; or

5. Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress;

AND

B. Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or eleswhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors);

OR

C. Resulting in complete inability to function independently outside the area of one's home.

12.07 *Somatoform Disorders:* Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented by evidence of one of the following:

1. A history of multiple physical symptoms of several years duration, beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; or

2. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures, akinesia, dyskinesia; or

f. Sensation (e.g., diminished or heightened).

3. Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or

2. Marked difficulties in maintaining social functioning; or

3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or

4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behavior).

12.08 *Personality Disorders:* A personality disorder exists when personality traits are inflexible and maladaptive and cause either significant impairment in social or occupational functioning or subjective distress. Characteristic features are typical of the individual's long-term functioning and are not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior associated with one of the following:

1. Seclusiveness or autistic thinking; or
2. Pathologically inappropriate suspiciousness or hostility; or
3. Oddities of thought, perception, speech and behavior; or
4. Persistent disturbances of mood or affect; or
5. Pathological dependence, passivity, or aggressivity; or
6. Intense and unstable interpersonal relationships and impulsive and damaging behavior;

AND

B. Resulting in three of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Deficiencies of concentration, persistence or pace resulting in frequent failure to complete tasks in a timely manner (in work settings or elsewhere); or
4. Repeated episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors).

12.09 *Substance Addiction Disorders:* Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.

A. Organic mental disorders. Evaluate under 12.02.

B. Depressive syndrome. Evaluate under 12.04.

C. Anxiety disorders. Evaluate under 12.06.

D. Personality disorders. Evaluate under 12.08.

E. Peripheral neuropathies. Evaluate under 11.14.

F. Liver damage. Evaluate under 5.05.

G. Gastritis. Evaluate under 5.04.

H. Pancreatitis. Evaluate under 5.08.

I. Seizures. Evaluate under 11.02 or 11.03.

13.00 Neoplastic Diseases, Malignant

A. *Introduction:* The determination of the level of impairment resulting from malignant tumors is made from a consideration of the site of the lesion, the histogenesis of the tumor, the extent of involvement, the apparent adequacy and response to therapy (surgery, irradiation, hormones, chemotherapy, etc.), and the magnitude of the post therapeutic residuals.

B. *Documentation:* The diagnosis of malignant tumors should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen. If these documents are not obtainable, then the summary of hospitalization or a report from the treating physician must include details of the findings at surgery and the results of the pathologist's gross and microscopic examination of the tissues.

For those cases in which a disabling impairment was not established when therapy was begun but progression of the disease is likely, current medical evidence should include a report of a recent examination directed especially at local or regional recurrence, soft part or skeletal metastases, and significant posttherapeutic residuals.

C. *Evaluation.* Usually, when the malignant tumor consists of a local lesion with metastases to the regional lymph nodes which apparently has been completely excised, imminent recurrence or metastases is not anticipated. A number of exceptions are noted in the specific Listings. For adjudicative purposes, ''distant metastases'' or ''metastases beyond the regional lymph nodes'' refers to metastasis beyond the lines of the usual radical en bloc resection.

Local or regional recurrence after radical surgery or pathological evidence of incomplete excision by radical surgery is to be equated with unresectable lesions (except for carcinoma of the breast, 13.09C) and, for the purposes of our program, may be evaluated as ''inoperable.''

Local or regional recurrence after incomplete excision of a localized and still completely resectable tumor is not to be equated with recurrence after radical surgery. In the evaluation of lymphomas, the tissue type and site of involvement are not necessarily indicators of the degree of impairment.

When a malignant tumor has metastasized beyond the regional lymph nodes, the impairment will usually be found to meet the requirements of a specific listing. Exceptions are hormone-dependent tumors, isotope-sensitive metastases, and metastases from seminoma of the testicles which are controlled by definitive therapy.

When the original tumor and any metastases have apparently disappeared and have not been evident for 3 or more years, the impairment does not meet the criteria under this body system.

D. *Effects of therapy.* Significant posttherapeutic residuals, not specifically included in the category of impairments for malignant neoplasms, should be evaluated according to the affected body system.

Where the impairment is not listed in the Listing of Impairments and is not medically equivalent to a listed impairment, the impact of any residual impairment including

that caused by therapy must be considered. The therapeutic regimen and consequent adverse response to therapy may vary widely; therefore, each case must be considered on an individual basis. It is essential to obtain a specific description of the therapeutic regimen, including the drugs given, dosage, frequency of drug administration, and plans for continued drug administration. It is necessary to obtain a description of the complications or any other adverse response to therapy such as nausea, vomiting, diarrhea, weakness, dermatologic disorders, or reactive mental disorders. Since the severity of the adverse effects of anticancer chemotherapy may change during the period of drug administration, the decision regarding the impact of drug therapy should be based on a sufficient period of therapy to permit proper consideration.

E. *Onset.* To establish onset of disability prior to the time a malignancy is first demonstrated to be inoperable or beyond control by other modes of therapy (and prior evidence is nonexistent) requires medical judgment based on medically reported symptoms, the type of the specific malignancy, its location, and extent of involvement when first demonstrated.

13.01 Category of Impairments, Neoplastic Diseases—Malignant

13.02 *Head and neck* (except salivary glands—13.07, thyroid gland—13.08, and mandible, maxilla, orbit, or temporal fossa—13.11):

A. Inoperable; or

B. Not controlled by prescribed therapy; or

C. Recurrent after radical surgery or irradiation; or

D. With distant metastases; or

E. Epidermoid carcinoma occurring in the pyriform sinus or posterior third of the tongue.

13.03 *Sarcoma of skin:*

A. Angiosarcoma with metastases to regional lymph nodes or beyond; or

B. Mycosis fungoides with metastases to regional lymph nodes, or with visceral involvement.

13.04 *Sarcoma of soft parts:* Not controlled by prescribed therapy.

13.05 *Malignant melanoma:*

A. Recurrent after wide excision; or

B. With metastases to adjacent skin (satellite lesions) or elsewhere.

13.06 *Lymph nodes:*

A. Hodgkin's disease or non-Hodgkin's lymphoma with progressive disease not controlled by prescribed therapy; or

B. Metastatic carcinoma in a lymph node (except for epidermoid carcinoma in a lymph node in the neck) where the primary site is not determined after adequate search; or

C. Epidermoid carcinoma in a lymph node in the neck not responding to prescribed therapy.

13.07 *Salivary glands*— carcinoma or sarcoma with metastases beyond the regional lymph nodes.

13.08 *Thyroid gland*—carcinoma with metastases beyond the regional lymph nodes, not controlled by prescribed therapy.

13.09 *Breast:*

A. Inoperable carcinoma; or

B. Inflammatory carcinoma; or

C. Recurrent carcinoma, except local recurrence controlled by prescribed therapy; or

D. Distant metastases from breast carcinoma (bilateral breast carcinoma, synchronous or metachronous is usually primary in each breast); or

E. Sarcoma with metastases anywhere.

13.10 *Skeletal system* (exclusive of the jaw):

A. Malignant primary tumors with evidence of metastases and not controlled by prescribed therapy; or

B. Metastatic carcinoma to bone where the primary site is not determined after adequate search.

13.11 *Mandible, maxilla, orbit, or temporal fossa:*

A. Sarcoma of any type with metastases; or

B. Carcinoma of the antrum with extension into the orbit or ethmoid or sphenoid sinus, or with regional or distant metastases; or

C. Orbital tumors with intracranial extension; or

D. Tumors of the temporal fossa with perforation of skull and meningeal involvement; or

E. Adamantinoma with orbital or intracranial infiltration; or

F. Tumors of Rathke's pouch with infiltration of the base of the skull or metastases.

13.12 *Brain or spinal cord:*

A. Metastatic carcinoma to brain or spinal cord.

B. Evaluate other tumors under the criteria described in 11.05 and 11.08.

13.13 *Lungs.*

A. Unresectable or with incomplete excision; or

B. Recurrence or metastases after resection; or

C. Oat cell (small cell) carcinoma; or

D. Squamous cell carcinoma, with metastases beyond the hilar lymph nodes; or

E. Other histologic types of carcinoma, including undifferentiated and mixed-cell types (but excluding oat cell carcinoma, 13.13C, and squamous cell carcinoma, 13.13D), with metastases to the hilar lymph nodes.

13.14 *Pleura or mediastinum:*

A. Malignant mesothelioma of pleura; or

B. Malignant tumors, metastatic to pleura; or

C. Malignant primary tumor of the mediastinum not controlled by prescribed therapy.

13.15 *Abdomen:*

A. Generalized carcinomatosis; or

B. Retroperitoneal cellular sarcoma not controlled by prescribed therapy; or

C. Ascites with demonstrated malignant cells.

13.16 *Esophagus or stomach:*

A. Carcinoma or sarcoma of the esophagus; or

B. Carcinoma of the stomach with metastases to the regional lymph nodes or extension to surrounding structure; or

C. Sarcoma of stomach not controlled by prescribed therapy; or

D. Inoperable carcinoma; or

E. Recurrence or metastases after resection.

13.17 *Small intestine:*

A. Carcinoma, sarcoma, or carcinoid tumor with metastases beyond the regional lymph nodes; or

B. Recurrence of carcinoma, sarcoma, or carcinoid tumor after resection; or

C. Sarcoma, not controlled by prescribed therapy.

13.18 *Large intestine* (from ileocecal valve to and including anal canal)—carcinoma or sarcoma.

A. Unresectable; or

B. Metastases beyond the regional lymph nodes; or

C. Recurrence or metastases after resection.

13.19 *Liver or gallbladder:*

A. Primary or metastatic malignant tumors of the liver; or

B. Carcinoma of the gallbladder; or

C. Carcinoma of the bile ducts.

13.20 *Pancreas:*

A. Carcinoma except islet cell carcinoma; or

B. Islet cell carcinoma which is unresectable and physiologically active.

13.21 *Kidneys, adrenal glands, or ureters—carcinoma:*

A. Unresectable; or

B. With hematogenous spread to distant sites; or

C. With metastases to regional lymph nodes.

13.22 *Urinary bladder—carcinoma*. With:

A. Infiltration beyond the bladder wall; or

B. Metastases to regional lymph nodes; or

C. Unresectable; or

D. Recurrence after total cystectomy; or

E. Evaluate renal impairment after total cystectomy under the criteria in 6.02.

13.23 *Prostate gland*—carcinoma not controlled by prescribed therapy.

13.24 *Testicles:*

A. Choriocarcinoma; or

B. Other malignant primary tumors with progressive disease not controlled by prescribed therapy.

13.25 *Uterus*—carcinoma or sarcoma (corpus or cervix).

A. Inoperable and not controlled by prescribed therapy; or

B. Recurrent after total hysterectomy; or

C. Total pelvic exenteration

13.26 *Ovaries*—all malignant, primary or recurrent tumors. With:

A. Ascites with demonstrated malignant cells; or

B. Unresectable infiltration; or

C. Unresectable metastases to omentum or elsewhere in the peritoneal cavity; or

D. Distant metastases.

13.27 *Leukemia:* Evaluate under the criteria of 7.00ff, Hemic and Lymphatic Sytem.

13.28 *Uterine (Fallopian) tubes—carcinoma or sarcoma:*

A. Unresectable, or

B. Metastases to regional lymph nodes.

13.29 *Penis—carcinoma with metastases to regional lymph nodes.*

13.30 *Vulva—carcinoma, with distant metastases.*

14.00 Immune System

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. They generally evolve and persist for months or years, may result in loss of functional abilities, and may require long-term, repeated evaluation and management.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

To permit appropriate application of a listing, the specific diagnostic features that should be documented in the clinical record for each of the disorders are summarized for systemic lupus erythematosus (SLE), systemic vasculitis, systemic sclerosis and scleroderma, polymyositis or dermatomyositis, and undifferentiated connective tissue disorders.

In addition to the limitations caused by the connective tissue disorder *per se,* the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

These disorders may preclude performance of any gainful activity by reason of severe loss of function in a single organ or body system, or lesser degrees of functional loss in two or more organs/body systems associated with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. We use the term ''severe'' in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

1. Systemic lupus erythematosus (14.02)—This disease is characterized clinically by constitutional symptoms and signs (e.g., fever, fatigability, malaise, weight loss), multisystem involvement and, frequently, anemia, leukopenia, or thrombocytopenia. Immunologically, an array of circulating serum auto-antibodies can occur, but are highly variable in pattern. Generally the medical evidence will show that patients with this disease will fulfill The 1982 Revised Criteria for the Classification of Systemic Lupus Erythematosus of the American College of Rheumatology. (Tan, E.M., et al., Arthritis Rheum. 25: 11271–1277, 1982).

2. Systemic vasculitis (14.03)—This disease occurs acutely in association with adverse drug reactions, certain chronic infections and, occasionally, malignancies. More often it is idiopathic and chronic. There are several clinical patterns, including classical polyarteritis nodosa, aortic arch arteritis, giant cell arteritis, Wegener's granulomatosis, and vasculitis associated with other connective tissue disorders (e.g., rheumatoid arthritis, SLE, Sjogren's syndrome, cryoglobulinemia). Cutaneous vasculitis may or may not be associated with systemic involvement and the patterns of vascular and ischemic involvement are highly variable. The diagnosis is confirmed by angiography or tissue biopsy when the disease is suspected clinically. Most patients who are stated to have this disease will have the results of the confirmatory angiogram or biopsy in their medical records.

3. Systemic sclerosis and scleroderma (14.04)—These disorders constitute a spectrum of disease in which thickening of the skin is the clinical hallmark. Raynaud's phenomena, often severe and progressive, are especially frequent and may be the peripheral manifestation of a generalized vasospastic abnormality in the heart, lungs, and kidneys. The CREST syndrome (calcinosis, Raynaud's phenomena, esophageal dysmotility, sclerodactyly, telangiectasia) is a variant that may slowly progress to the generalized process, systemic sclerosis, over years. In addition to skin and blood vessels, the major organ/body system involvement includes the gastrointestinal tract, lungs, heart, kidneys, and muscle. Although arthritis can occur, joint dysfunction results primarily from soft tissue/cutaneous thickening, fibrosis, and contractures.

4. Polymyositis or dermatomyositis (14.05)—This disorder is primarily an inflammatory process in striated muscle, which can occur alone or in association with other connective tissue disorders or malignancy. Weakness and, less frequently, pain and tenderness of the proximal limb-girdle musculature are the cardinal manifestations. Involvement of the cervical muscles, the cricopharyngeals, the intercostals, and diaphragm may occur in those with listing-level disease. Weakness of the pelvic girdle, as contemplated in Listing 14.05A, may result in significant difficulty climbing stairs or rising from a chair without use of the arms. Proximal limb weakness in the upper extremities may result in inability to lift objects, and interference with dressing and combing hair. Weakness of anterior neck flexors may impair the ability to lift the head from the pillow in bed. The diagnosis is supported by elevated serum muscle enzymes (creatine phosphokinase (CPK), aminotransferases, aldolase), characteristic abnormalities on electromyography, and myositis on muscle biopsy.

5. Undifferentiated connective tissue disorder (14.06)—This listing includes syndromes with clinical and immunologic features of several connective tissue disorders, but that do not satisfy the criteria for any of the disorders described; for instance, the individual may have clinical features of systemic lupus erythematosus and systemic vasculitis and the serologic findings of rheumatoid arthritis. It also includes overlap syndromes with clinical features of more than one established connective tissue disorder. For example, the individual may have features of both rheumatoid arthritis and scleroderma. The correct designation of this disorder is important for assessment of prognosis.

C. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 14.08. Any individual with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if

his or her impairment meets any of the criteria in 14.08 or is of equivalent severity to any impairment in 14.08.

2. Definitions. In 14.08, the terms ''resistant to treatment,'' ''recurrent,'' and ''disseminated'' have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

''Resistant to treatment'' means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

''Recurrent'' means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

''Disseminated'' means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

As used in 14.08I, ''significant involuntary weight loss'' does not correspond to a specific minimum amount or percentage of weight loss. Although, for purposes of this listing, an involuntary weight loss of at least 10 percent of baseline is always considered significant, loss of less than 10 percent may or may not be significant, depending on the individual's baseline weight and body habitus. (For example, a 7-pound weight loss in a 100-pound female who is 63 inches tall might be considered significant; but a 14-pound weight loss in a 200-pound female who is the same height might not be significant.)

3. Documentation of HIV infection. The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection by definitive diagnosis. A definitive diagnosis of HIV infection is documented by one or more of the following laboratory tests:

i. A serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. Other test(s) that are highly specific for detection of HIV (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

Individuals who have HIV infection or other disorders of the immune system may undergo tests to determine T-helper lymphocyte (CD4) counts. The extent of immune depression correlates with the level or rate of decline of the CD4 count. In general, when the CD4 count is 200/mm^3 or less (14 percent or less), the susceptibility to opportunistic disease is considerably increased. However, a reduced CD4 count alone does not establish a definitive diagnosis of HIV infection, or document the severity or functional effects of HIV infection.

b. Other acceptable documentation of HIV infection.

HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection will be accepted without definitive laboratory evidence if the individual has an opportunistic disease (e.g., toxoplasmosis of the brain, pneumocystis carinii pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection. The medical evidence must also include documentation of the manifestations of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever

this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count may show that there is an increased susceptibility to opportunistic infections and diseases (see 14.00D3a, above), that alone does not establish the presence, severity, or functional effects of a manifestation of HIV infection.

b. Other acceptable documentation of the manifestations of HIV infection.

Manifestations of HIV infection may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (14.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

5. Manifestations specific to women. Most women with severe immunosuppression secondary to HIV infection exhibit the typical opportunistic infections and other conditions, such as pneumocystis carinii pneumonia (PCP), candida esophagitis, wasting syndrome, cryptococcosis, and toxoplasmosis. However, HIV infection may have different manifestations in women than in men. Adjudicators must carefully scrutinize the medical evidence and be alert to the variety of medical conditions specific to or common in women with HIV infection that may affect their ability to function in the workplace.

Many of these manifestations (e.g. vulvovaginal candidiasis, pelvic inflammatory disease) occur in women with or without HIV infection, but can be more severe or resistant to treatment, or occur more frequently in a woman whose immune system is suppressed. Therefore, when evaluating the claim of a woman with HIV infection, it is important to consider gynecologic and other problems specific to women, including any associated symptoms (e.g., pelvic pain), in assessing the severity of the impairment and resulting functional limitations. Manifestations of HIV infection in women may be evaluated under the specific criteria (e.g., cervical cancer under 14.08E), under an applicable general category (e.g., pelvic inflammatory disease under 14.08A5) or, in appropriate cases, under 14.08N.

6. Evaluation. The criteria in 14.08 do not describe the full spectrum of diseases or conditions manifested by individuals with HIV infection. As in any case, consideration must be given to whether an individual's impairment(s) meets or equals in severity any other listing in appendix 1 of subpart P (e.g., a neoplastic disorder listed in 13.00ff). Although 14.08 includes cross-references to other listings for the more common manifestations of HIV infection, other listings may apply.

In addition, the impact of all impairments, whether or not related to HIV infection, must be considered. For example, individuals with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments, and the impairment(s) should be evaluated not only under the relevant listing(s) in 14.08, but under any other appropriate listing(s).

It is also important to remember that individuals with HIV infection, like all other individuals, are evaluated under the full five-step sequential evaluation process described in § 404.1520 and § 416.920. If an individual with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the sequential evaluation process, and does not require evaluation under these listings. For an individual with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet or equal in severity the criteria of a listing, evaluation must proceed through the final steps of the sequential evaluation process (or, as appropriate, the steps in the medical improvement review standard) before any conclusion can be reached on the issue of disability.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g., antiretroviral agents) and in terms of any side effects of treatment that may further impair the individual.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, an individual with HIV infection who develops pneumonia or tuberculosis may respond to the same antibiotic regimen used in treating individuals without HIV infection, but another individual with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the individual's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long term. As such, the decision regarding the impact of treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph N of 14.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 14.08A–M. Paragraph N is applicable for manifestations that are not listed in 14.08A–M, as well as those listed in 14.08A–M that do not meet the criteria of any of the rules in 14.08A–M.

For individuals with HIV infection evaluated under 14.08N, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the claimant's ability to function must be considered. Important factors to be considered in evaluating the functioning of individuals with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

As used in 14.08N, ''repeated'' means that the conditions occur on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or the conditions do not last for 2 weeks but occur substantially more frequently than 3 times in a year or once every 4 months; or they occur less often than an average of 3 times a year or once every 4 months but last substantially longer than 2 weeks.

To meet the criteria in 14.08N, an individual with HIV infection must demonstrate a marked level of restriction in one of three general areas of functioning: activities of daily living; social functioning; and difficulties in completing tasks due to deficiencies in concentration, persistence, or pace. Functional restrictions may result from the impact of the disease process itself on mental or physical functioning, or both. This could result from extended or intermittent symptoms, such as depression, fatigue, or pain, resulting in a limitation of the ability to concentrate, to persevere at a task, or to perform the task at an acceptable rate of speed. Limitations may also result from the side effects of medication.

When ''marked'' is used as a standard for measuring the degree of functional limitation, it means more than moderate, but less than extreme. A marked limitation does not represent a quantitative measure of the individual's ability to do an activity for a certain percentage of the time. A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. However, an individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively. The term ''marked'' does not imply that the impaired individual is confined to bed, hospitalized, or in a nursing home.

Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills. An individual with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

Social functioning includes the capacity to interact appropriately and communicate effectively with others. An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty maintaining social functioning.

Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings. An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

14.01 Category of Impairments, Immune System

14.02 Systemic lupus erythematosus. Documented as described in 14.00B1, with:

A. One of the following:

1. Joint involvement, as described under the criteria in 1.00; or

2. Muscle involvement, as described under the criteria in 14.05; or

3. Ocular involvement, as described under the criteria in 2.00ff; or

4. Respiratory involvement, as described under the criteria in 3.00ff; or

5. Cardiovascular involvement, as described under the criteria in 4.00ff or 14.04D; or

6. Digestive involvement, as described under the criteria in 5.00ff; or

7. Renal involvement, as described under the criteria in 6.00ff; or

8. Skin involvement, as described under the criteria in 8.00ff; or

9. Neurological involvement, as described under the criteria in 11.00ff; or

10. Mental involvement, as described under the criteria in 12.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.03 Systemic vasculitis. Documented as described in 14.00B2, including documentation by angiography or tissue biopsy, with:

A. Involvement of a single organ or body system, as described under the criteria in 14.02A.

or

B. Lesser involvement of two or more organs/body systems listed in 14.02A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

14.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3, with:

A. One of the following:

1. Muscle involvement, as described under the criteria in 14.05; or

2. Respiratory involvement, as described under the criteria in 3.00ff; or

3. Cardiovascular involvement, as described under the criteria in 4.00ff; or

4. Digestive involvement, as described under the criteria in 5.00ff; or

5. Renal involvement, as described under the criteria in 6.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

or

C. Generalized scleroderma with digital contractures.

or

D. Severe Raynaud's phenomena, characterized by digital ulcerations, ischemia, or gangrene.

14.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4, with:

A. Severe proximal limb-girdle (shoulder and/or pelvic) muscle weakness, as described in 14.00B4.

or

B. Less severe limb-girdle muscle weakness than in 14.05A, associated with cervical muscle weakness and one of the following to at least a moderate level of severity:

1. Impaired swallowing with dysphagia and episodes of aspiration due to cricopharyngeal weakness, or

2. Impaired respiration due to intercostal and diaphragmatic muscle weakness.

or

C. If associated with malignant tumor, as described under the criteria in 13.00ff.

or

D. If associated with generalized connective tissue disease, described under the criteria in 14.02, 14.03, 14.04, or 14.06.

14.06 Undifferentiated connective tissue disorder. Documented as described in 14.00B5, and with impairment as described under the criteria in 14.02A, 14.02B, or 14.04.

14.07 Immunoglobulin deficiency syndromes or deficiencies of cell-mediated immunity, excepting HIV infection. Associated with documented, recurrent severe infection occurring 3 or more times within a 5-month period.

14.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 14.00D3 and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis) at a site other than the lungs, skin, or cervical or hilar lymph nodes; or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. Salmonella bacteremia, recurrent nontyphoid; or

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 2.00 Special Senses and Speech, 4.00 Cardiovascular System, 11.00 Neurological); or

5. Multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis.

or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or

3. Strongyloidiasis, extra-intestinal; or

4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 14.00D4b) at a site other than the liver, spleen, or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or

5. Hepatitis, as described under the criteria in 5.05.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Kaposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

c. Involvement of the skin or mucous membranes, as described under the criteria in 14.08F; or

3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkins lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3, above) with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease), or evaluate under the criteria in 8.00ff.

or

G. Hematologic abnormalities:

1. Anemia, as described under the criteria in 7.02; or

2. Granulocytopenia, as described under the criteria in 7.15; or

3. Thrombocytopenia, as described under the criteria in 7.06.

or

H. Neurological abnormalities:

1. HIV encephalopathy, characterized by cognitive or motor dysfunction that limits function and progresses; or

2. Other neurological manifestations of HIV infection (e.g., peripheral neuropathy) as described under the criteria in 11.00ff.

or

I. HIV wasting syndrome, characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss, as described in 14.00D2) and, in the absence of a concurrent illness that could explain the findings, either:

1. Chronic diarrhea with two or more loose stools daily lasting for 1 month or longer; or

2. Chronic weakness and documented fever greater than 38 °C (100.4 °F) for the majority of 1 month or longer.

or

J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

K. Cardiomyopathy, as described under the criteria in 4.00ff or 11.04.

or

L. Nephropathy, as described under the criteria in 6.00ff.

or

M. One or more of the following infections (other than described in A–L, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system).

1. Sepsis; or

2. Meningitis; or

3. Pneumonia; or

4. Septic arthritis; or

5. Endocarditis; or

6. Radiographically documented sinusitis.

or

N. Repeated (as defined in 14.00D8) manifestations of HIV infection (including those listed in 14.08A–M, but without the requisite findings, e.g., carcinoma of the cervix not meeting the criteria in 14.08E, diarrhea not

meeting the criteria in 14.08J, or other manifestations, e.g., oral hairy leukoplakia, myositis) resulting in significant, documented symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats) and one of the following at the marked level (as defined in 14.00D8):

1. Restriction of activities of daily living; or

2. Difficulties in maintaining social functioning; or

3. Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace.

Part B

Medical criteria for the evaluation of impairments of children under age 18 (where criteria in part A do not give appropriate consideration to the particular disease process in childhood).

Sec.
100.00 Growth Impairment.
101.00 Musculoskeletal System.
102.00 Special Senses and Speech.
103.00 Respiratory System.
104.00 Cardiovascular System.
105.00 Digestive System.
106.00 Genito-Urinary System.
107.00 Hemic and Lymphatic System.
108.00 [Reserved]
109.00 Endocrine System.
110.00 Multiple Body Systems.
111.00 Neurological.
112.00 Mental Disorders.
113.00 Neoplastic Diseases, Malignant.
114.00 Immune System.

100.00 GROWTH IMPAIRMENT

A. *Impairment of growth* may be disabling in itself or it may be an indicator of the severity of the impairment due to a specific disease process.

Determinations of growth impairment should be based upon the comparison of current height with at least three previous determinations, including length at birth, if available. Heights (or lengths) should be plotted on a standard growth chart, such as derived from the National Center for Health Statistics: NCHS Growth Charts. Height should be measured without shoes. Body weight corresponding to the ages represented by the heights should be furnished. The adult heights of the child's natural parents and the heights and ages of siblings should also be furnished. This will provide a basis upon which to identify those children whose short stature represents a familial characteristic rather than a result of disease. This is particularly true for adjudication under 100.02B.

B. *Bone age determinations* should include a full descriptive report of roentgenograms specifically obtained to determine bone age and must cite the standardization method used. Where roentgenograms must be obtained currently as a basis for adjudication under 100.03, views of the left hand and wrist should be ordered. In addition, roentgenograms of the knee and ankle should be obtained when cessation of growth is being evaluated in an older child at, or past, puberty.

C. The criteria in this section are applicable until closure of the major epiphyses. The cessation of significant increase in height at that point would prevent the application of these criteria.

100.01 Category of Impairments, Growth

100.02 *Growth impairment,* considered to be related to an additional specific medically determinable impairment, and one of the following:

A. Fall of greater than 15 percentiles in height which is sustained; or

B. Fall to, or persistence of, height below the third percentile.

100.03 *Growth impairment,* not identified as being related to an additional, specific medically determinable impairment. With:

A. Fall of greater than 25 percentiles in height which is sustained; and

B. Bone age greater than two standard deviations (2 SD) below the mean for chronological age (see 100.00B).

101.00 MUSCULOSKELETAL SYSTEM

A. *Rheumatoid arthritis.* Documentation of the diagnosis of juvenile rheumatoid arthritis should be made according to an established protocol, such as that published by the Arthritis Foundation, *Bulletin on the Rheumatic Diseases.* Vol. 23, 1972–1973 Series, p 712. Inflammatory signs include persistent pain, tenderness, erythema, swelling, and increased local temperature of a joint.

B. *The measurements of joint motion* are based on the technique for measurements described in the ''Joint Method of Measuring and Recording.'' published by the American Academy of Orthopedic Surgeons in 1965, or ''The Extremities and Back'' in *Guides to the Evaluation of Permanent Impairment,* Chicago, American Medical Association, 1971, Chapter 1, pp. 1–48.

C. *Degenerative arthritis* may be the end stage of many skeletal diseases and conditions, such as traumatic arthritis, collagen disorders septic arthritis, congenital dislocation of the hip, aseptic necrosis of the hip, slipped capital femoral epiphyses, skeletal dysplasias, etc.

101.01 Category of Impairments, Musculoskeletal

101.02 *Juvenile rheumatoid arthritis.* With:

A. Persistence or recurrence of joint inflammation despite three months of medical treatment and one of the following:

1. Limitation of motion of two major joints of 50 percent or greater; or

2. Fixed deformity of two major weight-bearing joints of 30 degrees or more; or

3. Radiographic changes of joint narrowing, erosion, or subluxation; or

4. Persistent or recurrent systemic involvement such as iridocyclitis or pericarditis; or

B. Steroid dependence.

101.03 *Deficit of musculoskeletal function* due to deformity or musculoskeletal disease and one of the following:

A. Walking is markedly reduced in speed or distance despite orthotic or prosthetic devices; or

B. Ambulation is possible only with obligatory bilateral upper limb assistance (e.g., with walker, crutches); or

C. Inability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene.

101.05 *Disorders of the spine.*

A. Fracture of vertebra with cord involvement (substantiated by appropriate sensory and motor loss); or

B. Scoliosis (congenital idiopathic or neuromyopathic). With:

1. Major spinal curve measuring 60 degrees or greater; or

2. Spinal fusion of six or more levels. Consider under a disability for one year from the time of surgery; thereafter evaluate the residual impairment; or

3. FEV (vital capacity) of 50 percent or less of predicted normal values for the individual's measured (actual) height; or

C. Kyphosis or lordosis measuring 90 degrees or greater.

101.08 *Chronic osteomyelitis* with persistence or recurrence of inflammatory signs or drainage for at least 6 months despite prescribed therapy and consistent radiographic findings.

102.00 Special Senses and Speech

A. *Visual impairments in children.* Impairment of central visual acuity should be determined with use of the standard Snellen test chart. Where this cannot be used, as in very young children, a complete description should be provided of the findings using other appropriate methods of examination, including a description of the techniques used for determining the central visual acuity for distance.

The accommodative reflex is generally not present in children under 6 months of age. In premature infants, it may not be present until 6 months plus the number of months the child is premature. Therefore absence of accommodative reflex will be considered as indicating a visual impairment only in children above this age (6 months).

Documentation of a visual disorder must include description of the ocular pathology.

B. *Hearing impairments in children.* The criteria for hearing impairments in children take into account that a lesser impairment in hearing which occurs at an early age may result in a severe speech and language disorder.

Improvement by a hearing aid, as predicted by the testing procedure, must be demonstrated to be feasible in that child, since younger children may be unable to use a hearing aid effectively.

The type of audiometric testing performed must be described and a copy of the results must be included. The pure tone air conduction hearing levels in 102.08 are based on American National Standard Institute Specifications for Audiometers, S3.6–1969 (ANSI–1969). The report should indicate the specifications used to calibrate the audiometer.

The finding of a severe impairment will be based on the average hearing levels at 500, 1000, 2000, and 3000 Hertz (Hz) in the better ear, and on speech discrimination, as specified in § 102.08.

102.01 Category of Impairments, Special Sense Organs

102.02 *Impairments of central visual acuity.*

A. Remaining vision in the better eye after best correction is 20/200 or less; or

B. For children below 3 years of age at time of adjudication:

1. Absence of accommodative reflex (see 102.00A for exclusion of children under 6 months of age); or

2. Retrolental fibroplasia with macular scarring or neovascularization; or

3. Bilateral congenital cataracts with visualization of retinal red reflex only or when associated with other ocular pathology.

102.08 *Hearing impairments.*

A. For children below 5 years of age at time of adjudication, inability to hear air conduction thresholds at an average of 40 decibels (db) hearing level or greater in the better ear; or

B. For children 5 years of age and above at time of adjudication:

1. Inability to hear air conduction thresholds at an average of 70 decibels (db) or greater in the better ear; or

2. Speech discrimination scores at 40 percent or less in the better ear; or

3. Inability to hear air conduction thresholds at an average of 40 decibels (db) or greater in the better ear, and a speech and language disorder which significantly affects the clarity and content of the speech and is attributable to the hearing impairment.

103.00 Respiratory System

A. *Introduction.* The listings in this section describe impairments resulting from respiratory disorder based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of treatment prescribed by a treating source. Respiratory disorders, along with any associated impairment(s) must be established by medical evidence. Evidence must be provided in sufficient detail to permit an independent reviewer to evaluate the severity of the

impairment. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood respiratory impairments or a qualified pediatrician.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is such evidence, the longitudinal clinical record must include a description of the treatment prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed treatment and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community, despite the existence of a severe impairment(s). A child who does not receive treatment may or may not be able to show an impairment that meets the criteria of these listings. Even if a child does not show that his or her impairment meets the criteria of these listings, the child may have an impairment(s) that is medically or functionally equivalent in severity to one of the listed impairments. Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, the asthma listing specifically includes a requirement for continuing signs and symptoms despite a regimen of prescribed treatment.

Evaluation should include consideration of adverse effects of respiratory impairment in all relevant body systems, and especially on the child's growth and development or mental functioning, as described under the growth impairment (100.00), neurological (111.00), and mental disorders (112.00) listings.

It must be remembered that these listings are only examples of common respiratory disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§404.1526, 416.926, and 416.926a.)

B. *Documentation of Pulmonary Function Testing.* The results of spirometry that are used for adjudication, under the 103.02 A and B, 103.03, and 103.04 of these listings should be expressed in liters (L), body temperature and pressure saturated with water vapor (BTPS). The reported one-second forced expiratory volume (FEV_1) and forced vital capacity (FVC) should represent the largest of at least three satisfactory forced expiratory maneuvers. Two of the satisfactory spirograms should be reproducible for both pre-bronchodilator tests and, if indicated, post-bronchodilator tests. A value is considered reproducible if it does not differ from the largest value by more than 5 percent or 0.1 L, whichever is greater. The highest values of the FEV_1 and FVC, whether from the same or different tracings, should be used to assess the severity of the respiratory impairment. Peak flow should be achieved early in expiration, and the spirogram should have a smooth contour with gradually decreasing flow throughout expiration. The zero time for measurement of the FEV_1 and FVC, if not distinct, should be derived by linear back-extrapolation of peak flow to zero volume. A spirogram is satisfactory for measurement of the FEV_1 if the expiratory volume at the back-extrapolated zero time is less than 5 percent of the FVC or 0.1 L, whichever is greater. The spirogram is satisfactory for measurement of the FVC if maximal expiratory effort continues for at least 6 seconds, or if there is a plateau in the volume-time curve with no detectable change in expired volume (VE) during the last 2 seconds of maximal expiratory effort.

Spirometry should be repeated after administration of an aerosolized bronchodilator under supervision of the testing personnel if the pre-bronchodilator FEV_1 value is less than the appropriate reference value in table I or III, as appropriate. If a bronchodilator is not administered, the reason should be clearly stated in the report. Pulmonary function studies should not be performed unless the clinical status is stable (e.g., the child is not having an asthmatic attack or suffering from an acute respiratory infection or other chronic illness). Wheezing is common in asthma, chronic bronchitis, or chronic obstructive pulmonary disease and does not preclude testing. Pulmonary function studies performed to assess airflow obstruction without testing after bronchodilators cannot be used to assess levels of impairment in the range that prevents a child from performing age-appropriate activities, unless the use of bronchodilators is contraindicated. Post-bronchodilator testing should be performed 10 minutes after bronchodilator administration. The dose and name of the bronchodilator administered should be specified. The values in 103.02 and 103.04 must only be used as criteria for the level of ventilatory impairment that exists during the child's most stable state of health (i.e., any period in time except during or shortly after an exacerbation).

The appropriately labeled spirometric tracing, showing the child's name, date of

testing, distance per second on the abscissa and distance per liter (L) on the ordinate, must be incorporated into the file. The manufacturer and model number of the device used to measure and record the spirogram should be stated. The testing device must accurately measure both time and volume, the latter to within 1 percent of a 3 L calibrating volume. If the spirogram was generated by any means other than direct pen linkage to a mechanical displacement-type spirometer, the spirometric tracing must show a recorded calibration of volume units using a mechanical volume input such as a 3 L syringe.

If the spirometer directly measures flow, and volume is derived by electronic integration, the linearity of the device must be documented by recording volume calibrations at three different flow rates of approximately 30 L/min (3 L/6 sec), 60 L/min (3 L/3 sec), and 180 L/min (3 L/sec). The volume calibrations should agree to within 1 percent of a 3 L calibrating volume. The proximity of the flow sensor to the child should be noted, and it should be stated whether or not a BTPS correction factor was used for the calibration recordings and for the child's actual spirograms.

The spirogram must be recorded at a speed of at least 20 mm/sec and the recording device must provide a volume excursion of at least 10 mm/L. If reproductions of the original spirometric tracings are submitted, they must be legible and have a time scale of at least 20 mm/sec and a volume scale of at least 10 mm/L to permit independent measurements. Calculation of FEV_1 from a flow volume tracing is not acceptable, i.e., the spirogram and calibrations must be presented in a volume-time format at a speed of at least 20 mm/sec and a volume excursion of at least 10 mm/L to permit independent evaluation.

A statement should be made in the pulmonary function test report of the child's ability to understand directions, as well as his or her efforts and cooperation in performing the pulmonary function tests.

Purchase of a pulmonary function test is appropriate only when the child is capable of performing reproducible forced expiratory maneuvers. This capability usually occurs around age 6. Purchase of a pulmonary function test may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

The pulmonary function tables in 103.02 and 103.04 are based on measurement of standing height without shoes. If a child has marked spinal deformities (e.g., kyphoscoliosis), the measured span between the fingertips with the upper extremities abducted 90 degrees should be substituted for height when this measurement is greater than the standing height without shoes.

C. *Documentation of chronic impairment of gas exchange.*

1. *Arterial blood gas studies (ABGS).* An ABGS performed at rest (while breathing room air, awake and sitting or standing) should be analyzed in a laboratory certified by a State or Federal agency. If the laboratory is not certified, it must submit evidence of participation in a national proficiency testing program as well as acceptable quality control at the time of testing. The report should include the altitude of the facility and the barometric pressure on the date of analysis.

Purchase of resting ABGS may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided. Before purchasing resting ABGS, a program physician, preferably one experienced in the care of children with pulmonary disease, must review the clinical and laboratory data short of this procedure, including spirometry, to determine whether obtaining the test would present a significant risk to the child.

2. *Oximetry.* Pulse oximetry may be substituted for arterial blood gases in children under 12 years of age. The oximetry unit should employ the basic technology of spectrophotometric plethysmography as described in Taylor, M.B., and Whitwain, J.G., ''Current Status of Pulse Oximetry,'' ''Anesthesia,'' Vol. 41, No. 9, pp. 943–949, 1986. The unit should provide a visual display of the pulse signal and the corresponding oxygen saturation. A hard copy of the readings (heart rate and saturation) should be provided. Readings should be obtained for a minimum of 5 minutes. The written report should describe patient activity during the recording, i.e., sleep rate, feeding, or exercise. Correlation between the actual heart rate determined by a trained observer and that displayed by the oximeter should be provided. A statement should be made in the report of the child's effort and cooperation during the test.

Purchase of oximetry may be appropriate when there is a question of whether an impairment meets or is equivalent in severity to a listing, and the claim cannot otherwise be favorably decided.

D. *Cystic fibrosis* is a disorder that affects either the respiratory or digestive body systems or both and may impact on a child's growth and development. It is responsible for a wide and variable spectrum of clinical manifestations and complications. Confirmation of the diagnosis is based upon an elevated sweat sodium concentration or chloride concentration accompanied by one or more of the following: the presence of chronic obstructive pulmonary disease, insufficiency of exocrine pancreatic function, meconium ileus, or a positive family history. The quantitative pilocarpine iontophoresis

procedure for collection of sweat content must be utilized. Two methods are acceptable: the ''Procedure for the Quantitative Iontophoretic Sweat Test for Cystic Fibrosis,'' published by the Cystic Fibrosis Foundation and contained in, ''A Test for Concentration of Electrolytes in Sweat in Cystic Fibrosis of the Pancreas Utilizing Pilocarpine Iontophoresis,'' Gibson, I.E., and Cooke, R.E., ''Pediatrics,'' Vol 23: 545, 1959; or the ''Wescor Macroduct System.'' To establish the diagnosis of cystic fibrosis, the sweat sodium or chloride content must be analyzed quantitatively using an acceptable laboratory technique. Another diagnostic test is the ''CF gene mutation analysis'' for homozygosity of the cystic fibrosis gene. The pulmonary manifestations of this disorder should be evaluated under 103.04. The nonpulmonary aspects of cystic fibrosis should be evaluated under the listings for the digestive system (105.00) or growth impairments (100.00). Because cystic fibrosis may involve the respiratory and digestive body systems, as well as impact on a child's growth and development, the combined effects of this involvement must be considered in case adjudication.

E. *Bronchopulmonary dysplasia (BPD).* Bronchopulmonary dysplasia is a form of chronic obstructive pulmonary disease that arises as a consequence of acute lung injury in the newborn period and treatment of hyaline membrane disease, meconium aspiration, neonatal pneumonia and apnea of prematurity. The diagnosis is established by the requirement for continuous or nocturnal supplemental oxygen for more than 30 days, in association with characteristic radiographic changes and clinical signs of respiratory dysfunction, including retractions, rales, wheezing, and tachypnea.

103.01 Category of Impairments, Respiratory System

103.02 *Chronic pulmonary insufficiency*. With:

A. Chronic obstructive pulmonary disease, due to any cause, with the FEV_1 equal to or less than the value specified in table I corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE I

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120–129	47–50	0.75
130–139	51–54	0.95
140–149	55–58	1.15
150–159	59–62	1.35
160–164	63–64	1.45
165–169	65–66	1.55
170 or more	67 or more	1.65

Or

B. Chronic restrictive ventilatory disease, due to any cause, with the FVC equal to or less than the value specified in table II corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

TABLE II

Height without shoes (centimeters)	Height without shoes (inches)	FVC equal to or less than (L, BTPS)
119 or less	46 or less	0.65
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.25
150–159	59–62	1.45
160–164	63–64	1.65
165–169	65–66	1.75
170 or more	67 or more	2.05

Or

C Frequent need for:

1. Mechanical ventilation; or

2. Nocturnal supplemental oxygen as required by persistent or recurrent episodes of hypoxemia;

Or

D. The presence of a tracheostomy in a child under 3 years of age;

Or

E. Bronchopulmonary dysplasia characterized by two of the following:

1. Prolonged expirations; or

2. Intermittent wheezing or increased respiratory effort as evidenced by retractions, flaring and tachypnea; or

3. Hyperinflation and scarring on a chest radiograph or other appropriate imaging techniques; or

4. Bronchodilator or diuretic dependency; or

5. A frequent requirement for nocturnal supplemental oxygen; or

6. Weight disturbance with:

a. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

b. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer;

Or

F. Two required hospital admissions (each longer than 24 hours) within a 6-month period for recurrent lower respiratory tract infections or acute respiratory distress associated with:

1. Chronic wheezing or chronic respiratory distress; or

2. Weight disturbance with:

a. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

b. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer;

Or

G. Chronic hypoventilation ($PaCO_2$ greater than 45 mm Hg) or chronic cor pulmonale as described under the appropriate criteria in 104.02;

Or

H. Growth impairment as described under the criteria in 100.00.

103.03 Asthma. With:

A. FEV_1 equal to or less than the value specified in table I of 103.02A;

Or

B. Attacks (as defined in 3.00C), in spite of prescribed treatment and requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for control of asthma counts as two attacks, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of attacks;

Or

C. Persistent low-grade wheezing between acute attacks or absence of extended symptom-free periods requiring daytime and nocturnal use of sympathomimetic bronchodilators with one of the following:

1. Persistent prolonged expiration with radiographic or other appropriate imaging techniques evidence of pulmonary hyperinflation or peribronchial disease; or

2. Short courses of corticosteroids that average more than 5 days per month for at least 3 months during a 12-month period;

Or

D. Growth impairment as described under the criteria in 100.00.

103.04 Cystic fibrosis. With:

A. An FEV_1 equal to or less than the appropriate value specified in table III corresponding to the child's height without shoes. (In cases of marked spinal deformity, see 103.00B.);

Or

B. For children in whom pulmonary function testing cannot be performed, the presence of two of the following:

1. History of dyspnea on exertion or accumulation of secretions as manifested by repetitive coughing or cyanosis; or

2. Persistent bilateral rales and rhonchi or substantial reduction of breath sounds related to mucous plugging of the trachea or bronchi; or

3. Radiographic evidence of extensive disease, such as thickening of the proximal bronchial airways or persistence of bilateral peribronchial infiltrates;

Or

C. Persistent pulmonary infection accompanied by superimposed, recurrent, symptomatic episodes of increased bacterial infection occurring at least once every 6 months and requiring intravenous or nebulization antimicrobial treatment;

Or

D. Episodes of bronchitis or pneumonia or hemoptysis (more than blood-streaked sputum) or respiratory failure (documented according to 3.00C), requiring physician intervention, occurring at least once every 2 months or at least six times a year. Each inpatient hospitalization for longer than 24 hours for treatment counts as two episodes, and an evaluation period of at least 12 consecutive months must be used to determine the frequency of episodes;

Or

E. Growth impairment as described under the criteria in 100.00.

TABLE III

[Applicable only for evaluation under 103.04A—cystic fibrosis]

Height without shoes (centimeters)	Height without shoes (inches)	FEV_1 equal to or less than (L, BTPS)
119 or less	46 or less	0.75
120–129	47–50	0.85
130–139	51–54	1.05
140–149	55–58	1.35
150–159	59–62	1.55
160–164	63–64	1.85
165–169	65–66	2.05
170 or more	67 or more	2.25

104.00 CARDIOVASCULAR SYSTEM

A. Introduction

The listings in this section describe childhood impairments resulting from congenital or acquired cardiovascular disease based on symptoms, physical signs, laboratory test abnormalities, and response to a regimen of therapy prescribed by a treating source. A longitudinal clinical record covering a period of not less than 3 months of observations and therapy is usually necessary for the assessment of severity and expected duration unless the child is a neonate or the claim can

be decided favorably on the basis of the current evidence. All relevant evidence must be considered in assessing a child's disability. Reasonable efforts should be made to ensure evaluation by a program physician specializing in childhood cardiovascular impairments or a qualified pediatrician.

Examples of congenital defects include: abnormalities of cardiac septation, such as ventricular septal defect or atrioventricular (AV) canal; abnormalities resulting in cyanotic heart disease, such as tetralogy of Fallot or transposition of the vessels; valvular defects or obstructions to ventricular outflow, including pulmonary or aortic stenosis and/or coarctation of the aorta; and major abnormalities of ventricular development, including hypoplastic left heart syndrome or pulmonary tricuspid atresia with hypoplastic right ventricle. Acquired heart disease may be due to cardiomyopathy, rheumatic heart disease, Kawasaki syndrome, or other etiologies. Recurrent arrhythmias, severe enough to cause functional impairment, may be seen with congenital or acquired heart disease or, more rarely, in children with structurally normal hearts.

Cardiovascular impairments, especially chronic heart failure and congenital heart disease, may result in impairments in other body systems including, but not limited to, growth, neurological, and mental. Therefore, evaluation should include consideration of the adverse effects of cardiovascular impairment in all relevant body systems, and especially on the child's growth and development, or mental functioning, as described under the Growth impairment (100.00), Neurological (111.00), and Mental retardation (112.05) listings.

Many children, especially those who have listing-level impairments, will have received the benefit of medically prescribed treatment. Whenever there is evidence of such treatment, the longitudinal clinical record must include a description of the therapy prescribed by the treating source and response, in addition to information about the nature and severity of the impairment. It is important to document any prescribed therapy and response because this medical management may have improved the child's functional status. The longitudinal record should provide information regarding functional recovery, if any.

Some children will not have received ongoing treatment or have an ongoing relationship with the medical community despite the existence of a severe impairment(s). Unless the claim can be decided favorably on the basis of the current evidence, a longitudinal record is still important because it will provide information about such things as the ongoing medical severity of the impairment, the level of the child's functioning, and the frequency, severity, and duration of symptoms. Also, several listings include a requirement for continuing signs and symptoms despite a regimen of prescribed treatment. Even though a child who does not receive treatment may not be able to show an impairment that meets the criteria of these listings, the child may have an impairment(s) that is medically or functionally equivalent in severity to one of the listed impairments.

Indeed, it must be remembered that these listings are only examples of common cardiovascular disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§404.1526, 416.926, and 416.926a.)

B. Documentation

Each child's file must include sufficiently detailed reports on history, physical examinations, laboratory studies, and any prescribed therapy and response to allow an independent reviewer to assess the severity and duration of the cardiovascular impairment. Data should be obtained preferably from an office or center experienced in pediatric cardiac assessment. The actual electrocardiographic tracing (or adequately marked photocopy) and echocardiogram report with a copy of relevant echocardiographic views should be included (see part A, 4.00C1).

Results of additional studies necessary to substantiate the diagnosis or to document the severity of the impairment, including two-dimensional and Doppler echocardiography, and radionuclide ventriculograms, should be obtained as appropriate according to part A, 4.00C3. Ambulatory electrocardiographic monitoring may also be obtained if necessary to document the presence or severity of an arrhythmia.

Exercise testing, though increasingly used, is still less frequently indicated in children than in adults, and can rarely be successfully performed in children under 6 years of age. It may be of value in the assessment of some arrhythmias, in the assessment of the severity of chronic heart failure, and in the assessment of recovery of function following cardiac surgery or other therapy. It will only be purchased by the Social Security Administration if the case cannot be decided based on the available evidence and, if purchased, must be performed in a specialty center for pediatric cardiology or other facility qualified to perform exercise testing for children.

Purchased exercise tests should be performed using a generally accepted protocol consistent with the prevailing state of medical knowledge and clinical practice. An exercise test should not be purchased for a

child for whom the performance of the test is considered to constitute a significant risk by a program physician. See 4.00C2c.

Cardiac catheterization will not be purchased by the Social Security Administration. If the results of catheterization are otherwise available, they should be obtained.

C. Treatment and Relationship to Functional Status

In general, conclusions about the severity of a cardiovascular impairment cannot be made on the basis of type of treatment rendered or anticipated. The overall clinical and laboratory evidence, including the treatment plan(s) or results, should be persuasive that a listing-level impairment exists. The amount of function restored and the time required for improvement after treatment (medical, surgical, or a prescribed program of progressive physical activity) vary with the nature and extent of the disorder, the type of treatment, and other factors. Depending upon the timing of this treatment in relation to the alleged onset date of disability, impairment evaluation may need to be deferred for a period of up to 3 months from the date of treatment to permit consideration of treatment effects.

Evaluation should not be deferred if the claim can be favorably decided based upon the available evidence.

The most life-threatening forms of congenital heart disease and cardiac impairments, such as those listed in 104.00D, almost always require surgical treatment within the first year of life to prevent early death. Even with surgery, these impairments are so severe that it is likely that the impairment will continue to be disabling long enough to meet the duration requirement because of significant residual impairment post-surgery, or the recovery time from surgery, or a combination of both factors. Therefore, when the impairment is one of those named in 104.00D, or is as severe as one of those impairments, the presence of a listing-level impairment can usually be found on the basis of planned or actual cardiac surgery.

A child who has undergone surgical treatment for life-threatening heart disease will be found under a disability for 12 months following the date of surgery under 104.06H (for infants with life-threatening cardiac disease) or 104.09 (for a child of any age who undergoes cardiac transplantation) because of the uncertainty during that period concerning outcome or long-term results. After 12 months, continuing disability evaluation will be based upon residual impairment, which will consider the clinical course following treatment and comparison of symptoms, signs, and laboratory findings preoperatively and after the specified period. (See §404.1594 or §416.994a, as appropriate, for our rules on medical improvement and whether an individual is no longer disabled.)

D. Congenital Heart Disease

Some congenital defects usually lead to listing-level impairment in the first year of life and require surgery within the first year as a life-saving measure. Examples of impairments that in most instances will require life-saving surgery before age 1, include, but are not limited to, the following: hypoplastic left heart syndrome; critical aortic stenosis with neonatal heart failure; critical coarctation of the aorta, with or without associated anomalies; complete AV canal defects; transposition of the great arteries; tetralogy of Fallot; and pulmonary atresia with intact ventricular septum.

In addition, there are rarer defects which may lead to early mortality and that may require multiple surgical interventions or a combination of surgery and other major interventional procedures (e.g., multiple ''balloon'' catheter procedures). Examples of such defects include single ventricle, tricuspid atresia, and multiple ventricular septal defects.

Pulmonary vascular obstructive disease can cause cardiac impairment in young children. When a large or nonrestrictive septal defect or ductus is present, pulmonary artery mean pressures of at least 70 percent of mean systemic levels are used as a criterion of listing-level impairment. In the absence of such a defect (i.e., with primary pulmonary hypertension, or in some connective tissue disorders with cardiopulmonary involvement and pulmonary vascular destruction), listing-level impairment may be present at lower levels of pulmonary artery pressure, in the range of at least 50 percent of mean systemic levels.

E. Chronic Heart Failure

Chronic heart failure in infants and children may manifest itself by pulmonary or systemic venous congestion, including cardiomegaly, chronic dyspnea, tachypnea, orthopnea, or hepatomegaly; or symptoms of limited cardiac output, such as weakness or fatigue; or a need for cardiotonic drugs. Fatigue or exercise intolerance in an infant may be manifested by prolonged feeding time associated with signs of cardiac impairment, including excessive respiratory effort and sweating. Other manifestations of chronic heart failure during infancy may include failure to gain weight or involuntary loss of weight and repeated lower respiratory tract infections.

Cardiomegaly or ventricular dysfunction must be present and demonstrated by imaging techniques, such as two-dimensional and Doppler echocardiography. (Reference: Feigenbaum, Harvey, ''Echocardiography,'' 4th Edition, Lea and Febiger, 1986, Appendix, pp. 621–639.) Chest x-ray (6 ft. PA film) will be considered indicative of cardiomegaly if the cardiothoracic ratio is over 60 percent at

age 1 year or less, or 55 percent at more than 1 year of age.

Findings of cardiomegaly on chest x-ray must be accompanied by other evidence of chronic heart failure or ventricular dysfunction. This evidence may include clinical evidence, such as hepatomegaly, edema, or pulmonary venous congestion; or echocardiographic evidence, such as marked ventricular dilatation above established normals for age, or markedly reduced ejection fraction or shortening fraction.

F. Valvular Heart Disease

Valvular heart disease requires documentation by appropriate imaging techniques, including Doppler echocardiogram studies or cardiac catheterization if catheterization results are available from a treating source or other source of record. Listing-level impairment is usually associated with critical aortic stenosis in a newborn child, persistent heart failure, arrhythmias, or valve replacement and ongoing anticoagulant therapy. The usual time after valvular surgery for adequate assessment of the results of treatment is considered to be 3 months.

G. Rheumatic Heart Disease

The diagnosis should be made in accordance with the current revised Jones criteria for guidance in the diagnosis of rheumatic fever.

104.01 Category of Impairments, Cardiovascular System

104.02 *Chronic heart failure.* Documented by clinical and laboratory findings as described in 104.00E, and with one of the following:

A. Persistent tachycardia at rest (see table I);

OR

B. Persistent tachypnea at rest (see table II), or markedly decreased exercise tolerance (see 104.00E);

OR

C. Recurrent arrhythmias, as described in 104.05;

OR

D. Growth disturbance, with:

1. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) which persists for 2 months or longer; or

2. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) which persists for 2 months or longer; or

3. Growth impairment as described under the criteria in 100.00.

TABLE I—TACHYCARDIA AT REST

Age	Apical heart (beats per minute)
Under 1 yr	150
1 through 3 yrs	130
4 through 9 yrs	120
10 through 15 yrs	110
Over 15 yrs	100

TABLE II—TACHYPNEA AT REST

Age	Respiratory rate over (per minute)
Under 1 yr	40
1 through 5 yrs	35
6 through 9 yrs	30
Over 9 yrs	25

104.03 *Hypertensive cardiovascular disease.* With persistently elevated blood pressure equal to or greater than the 95th percentile for age (see table III), and one of the following:

A. Impaired renal function, as described in 106.02;

OR

B. Cerebrovascular damage, as described in 111.06;

OR

C. Chronic heart failure as described in 104.02.

TABLE III—ELEVATED BLOOD PRESSURE

Age	Systolic over (mmHg)	*OR*	Diastolic over (mmHg)
Under 1 month	95		—
1 month through 2 yrs	112		74
3 through 5 yrs	116		76
6 through 9 yrs	122		78
10 through 12 yrs	126		82
13 through 15 yrs	136		86
16 to 18 yrs	142		92

104.05 *Recurrent arrhythmias,* such as persistent or recurrent heart block (A–V dissociation), repeated symptomatic tachyarrhythmias or bradyarrhythmias or long QT syndrome arrhythmias, not related to reversible causes such as electrolyte abnormalities or digitalis glycoside or antiarrhythmic drug toxicity, resulting in uncontrolled repeated episodes of cardiac syncope or near syncope and arrhythmia despite prescribed treatment, including electronic pacemaker (see 104.00A if there is no prescribed treatment), and documented by

resting or ambulatory (Holter) electrocardiography coincident with the occurrence of syncope or near syncope.

104.06 *Congenital heart disease.* With one of the following:

A. Cyanotic heart disease, with persistent, chronic hypoxemia as manifested by:

1. Hematocrit of 55 percent or greater on two or more evaluations within a 3-month period; or

2. Arterial O_2 saturation of less than 90 percent in room air, or resting PO_2 of 60 Torr or less; or

3. Hypercyanotic spells, syncope, characteristic squatting, or other incapacitating symptoms directly related to documented cyanotic heart disease; or

4. Exercise intolerance with increased hypoxemia on exertion;

OR

B. Chronic heart failure with evidence of ventricular dysfunction, as described in 104.02;

OR

C. Recurrent arrhythmias as described in 104.05;

OR

D. Secondary pulmonary vascular obstructive disease with a mean pulmonary arterial pressure elevated to at least 70 percent of the mean systemic arterial pressure;

OR

E. Congenital valvular or other stenotic defects, or valvular regurgitation, as described in 104.00F and 104.07;

OR

F. Symptomatic acyanotic heart disease, with ventricular dysfunction resulting in significant restriction of age-appropriate activities or inability to complete age-appropriate tasks (see 104.00A);

OR

G. Growth failure, as described in 100.00;

OR

H. For infants under 12 months of age at the time of filing, with life-threatening congenital heart impairment that will or has required surgical treatment in the first year of life, consider the infant to be under a disability until the attainment of age 1 or for 12 months after surgery, whichever is the later event; thereafter, evaluate impairment severity with reference to 104.02 to 104.08.

104.07 *Valvular heart disease or other stenotic defects, or valvular regurgitation,* documented by appropriate imaging techniques or cardiac catheterization.

A. Evaluate according to criteria in 104.02, 104.05, 111.06, or 11.04;

OR

B. Critical aortic stenosis in newborn.

104.08 *Cardiomyopathies,* documented by appropriate imaging techniques, including echocardiography or cardiac catheterization, if catheterization results are available from a treating source. Impairment must be associated with an ejection fraction of 50 percent or less and significant left ventricular dilatation using standardized age-appropriate echocardiographic ventricular cavity measurements. Evaluate under the criteria in 104.02, 104.05, or 111.06.

104.09 *Cardiac transplantation.* Consider under a disability for 1 year following surgery; thereafter, evaluate residual impairment under 104.02 to 104.08.

104.13 *Chronic rheumatic fever or rheumatic heart disease.* Consider under a disability for 18 months from the established onset of impairment with one of the following:

A. Persistence of rheumatic fever activity for 6 months or more which is manifested by significant murmur(s), cardiac enlargement (see 104.00E) or ventricular dysfunction, and other abnormal laboratory findings, as for example, an elevated sedimentation rate or ECG findings;

OR

B. Evidence of chronic heart failure, as described under 104.02;

OR

C. Recurrent arrhythmias, as described under 104.05.

104.14 *Hyperlipidemia.* Documented Type II homozygous hyperlipidemia with repeated plasma cholesterol levels of 500 mg/ml or greater, with one of the following:

A. Myocardial ischemia, as described in 4.04B or 4.04C;

OR

B. Significant aortic stenosis documented by Doppler echocardiographic techniques or cardiac catheterization;

OR

C. Major disruption of normal life activities by repeated hospitalizations for plasmapheresis or other prescribed therapies, including liver transplant;

OR

D. Recurrent pancreatitis complicating hyperlipidemia.

104.15 *Kawasaki syndrome.* With one of the following:

A. Major coronary artery aneurysm;

OR

B. Chronic heart failure, as described in 104.02.

105.00 Digestive System

A. *Disorders of the digestive system* which result in disability usually do so because of interference with nutrition and growth, multiple recurrent inflammatory lesions, or other complications of the disease. Such lesions or complications usually respond to treatment. To constitute a listed impairment, these must be shown to have persisted

or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Documentation of gastrointestinal impairments* should include pertinent operative findings, radiographic studies, endoscopy, and biopsy reports. Where a liver biopsy has been performed in chronic liver disease, documentation should include the report of the biopsy.

C. *Growth retardation and malnutrition.* When the primary disorder of the digestive tract has been documented, evaluate resultant malnutrition under the criteria described in 105.08. Evaluate resultant growth impairment under the criteria described in 100.03. Intestinal disorders, including surgical diversions and potentially correctable congenital lesions, do not represent a severe impairment if the individual is able to maintain adequate nutrition growth and development.

D. *Multiple congenital anomalies.* See related criteria, and consider as a combination of impairments.

105.01 Category of Impairments, Digestive.

105.03 *Esophageal obstruction, caused by atresia, stricture, or stenosis* with malnutrition as described under the criteria in 105.08.

105.05 *Chronic liver disease.* With one of the following:

A. Inoperable billiary atresia demonstrated by X-ray or surgery; or

B. Intractable ascites not attributable to other causes, with serum albumin of 3.0 gm./100 ml. or less; or

C. Esophageal varices (demonstrated by angiography, barium swallow, or endoscopy or by prior performance of a specific shunt or plication procedure); or

D. Hepatic coma, documentated by findings from hospital records; or

E. Hepatic encephalopathy. Evaluate under the criteria in 112.02; or

F. Chronic active inflammation or necrosis documented by SGOT persistently more than 100 units or serum bilirubin of 2.5 mg. percent or greater.

105.07 *Chronic inflammatory bowel disease (such as ulcerative colitis, regional enteritis), as documented in 105.00.* With one of the following:

A. Intestinal manifestations or complications, such as obstruction, abscess, or fistula formation which has lasted or is expected to last 12 months; or

B. Malnutrition as described under the criteria in 105.08; or

C. Growth impairment as described under the criteria in 100.03.

105.08 *Malnutrition, due to demonstrable gastrointestinal disease causing either a fall of 15 percentiles of weight which persists or the persistence of weight which is less than the third percentile (on standard growth charts).* And one of the following:

A. Stool fat excretion per 24 hours:

1. More than 15 percent in infants less than 6 months.

2. More than 10 percent in infants 6–18 months.

3. More than 6 percent in children more than 18 months; or

B. Persistent hematocrit of 30 percent or less despite prescribed therapy; or

C. Serum carotene of 40 mcg./100 ml. or less; or

D. Serum albumin of 3.0 gm./100 ml. or less.

106.00 Genito-Urinary System

A. *Determination of the presence of chronic renal disease* will be based upon the following factors:

1. History, physical examination, and laboratory evidence of renal disease.

2. Indications of its progressive nature or laboratory evidence of deterioration of renal function.

B. *Renal transplant.* The amount of function restored and the time required to effect improvement depend upon various factors including adequacy of post transplant renal function, incidence of renal infection, occurrence of rejection crisis, presence of systemic complications (anemia, neuropathy, etc.) and side effects of corticosteroid or immuno-suppressive agents. A period of at least 12 months is required for the individual to reach a point of stable medical improvement.

C. Evaluate associated disorders and complications according to the appropriate body system listing.

106.01 Category of Impairments, Genito-Urinary.

106.02 *Chronic renal disease.* With:

A. Persistent elevation of serum creatinine to 3 mg. per deciliter (100 ml.) or greater over at least 3 months; or

B. Reduction of creatinine clearance to 30 ml. per minute (43 liters/24 hours) per 1.73 m^2 of body surface area over at least 3 months; or

C. Chronic renal dialysis program for irreversible renal failure; or

D. Renal transplant. Consider under a disability for 12 months following surgery; thereafter, evaluate the residual impairment (see 106.00B).

106.06 Nephrotic syndrome, with edema not controlled by prescribed therapy. And:

A. Serum albumin less than 2 gm./100 ml.; or

B. Proteinuria more than 2.5 gm./1.73m^2/day.

107.00 Hemic and Lymphatic System

A. *Sickle cell disease.* Refers to a chronic hemolytic anemia associated with sickle cell hemoglobin, either homozygous or in combination with thalassemia or with another abnormal hemoglobin (such as C or F).

Appropriate hematologic evidence for sickle cell disease, such as hemoglobin electrophoresis must be included. Vaso-occlusive, hemolytic, or aplastic episodes should be documented by description of severity, frequency, and duration.

Disability due to sickle cell disease may be solely the result of a severe, persistent anemia or may be due to the combination of chronic progressive or episodic manifestations in the presence of a less severe anemia.

Major visceral episodes causing disability include meningitis, osteomyelitis, pulmonary infections or infarctions, cerebrovascular accidents, congestive heart failure, genitourinary involvement, etc.

B. *Coagulation defects.* Chronic inherited coagulation disorders must be documented by appropriate laboratory evidence such as abnormal thromboplastin generation, coagulation time, or factor assay.

C. *Acute leukemia.* Initial diagnosis of acute leukemia must be based upon definitive bone marrow pathologic evidence. Recurrent disease may be documented by peripheral blood, bone marrow, or cerebrospinal fluid examination. The pathology report must be included.

The designated duration of disability implicit in the finding of a listed impairment is contained in 107.11. Following the designated time period, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of any remaining impairment must be evaluated on the basis of the medical evidence.

107.01 Category of Impairments, Hemic and Lymphatic.

107.03 *Hemolytic anemia (due to any cause).* Manifested by persistence of hematocrit of 26 percent or less despite prescribed therapy, and reticulocyte count of 4 percent or greater.

107.05 *Sickle cell disease.* With:

A. Recent, recurrent, severe vaso-occlusive crises (musculoskeletal, vertebral, abdominal); or

B. A major visceral complication in the 12 months prior to application; or

C. A hyperhemolytic or aplastic crisis within 12 months prior to application; or

D. Chronic, severe anemia with persistence of hematocrit of 26 percent or less; or

E. Congestive heart failure, cerebrovascular damage, or emotional disorder as described under the criteria in 104.02, 111.00ff, or 112.00ff.

107.06 *Chronic idiopathic thrombocytopenic purpura of childhood* with purpura and thrombocytopenia of 40,000 platelets/cu. mm. or less despite prescribed therapy or recurrent upon withdrawal of treatment.

107.08 *Inherited coagulation disorder.* With:

A. Repeated spontaneous or inappropriate bleeding; or

B. Hemarthrosis with joint deformity.

107.11 *Acute leukemia.* Consider under a disability:

A. For 2½ years from the time of initial diagnosis; or

B. For 2½ years from the time of recurrence of active disease.

108.00 [RESERVED]

109.00 ENDOCRINE SYSTEM

A. *Cause of disability.* Disability is caused by a disturbance in the regulation of the secretion or metabolism of one or more hormones which are not adequately controlled by therapy. Such disturbances or abnormalities usually respond to treatment. To constitute a listed impairment these must be shown to have persisted or be expected to persist despite prescribed therapy for a continuous period of at least 12 months.

B. *Growth.* Normal growth is usually a sensitive indicator of health as well as of adequate therapy in children. Impairment of growth may be disabling in itself or may be an indicator of a severe disorder involving the endocrine system or other body systems. Where involvement of other organ systems has occurred as a result of a primary endocrine disorder, these impairments should be evaluated according to the criteria under the appropriate sections.

C. *Documentation.* Description of characteristic history, physical findings, and diagnostic laboratory data must be included. Results of laboratory tests will be considered abnormal if outside the normal range or greater than two standard deviations from the mean of the testing laboratory. Reports in the file should contain the information provided by the testing laboratory as to their normal values for that test.

D. *Hyperfunction of the adrenal cortex.* Evidence of growth retardation must be documented as described in 100.00. Elevated blood or urinary free cortisol levels are not acceptable in lieu of urinary 17-hydroxycorticosteroid excretion for the diagnosis of adrenal cortical hyperfunction.

E. *Adrenal cortical insufficiency.* Documentation must include persistent low plasma cortisol or low urinary 17-hydroxycorticosteroids or 17-ketogenic steroids and evidence of unresponsiveness to ACTH stimulation.

109.01 Category of Impairments, Endrocrine

109.02 *Thyroid Disorders.*

A. Hyperthyroidism (as documented in 109.00C). With clinical manifestations despite prescribed therapy, and one of the following:

1. Elevated serum thyroxine (T_4) and either elevated free T_4 or resin T_3 uptake; or

2. Elevated thyroid uptake of radioiodine; or

3. Elevated serum triiodothyronine (T_3).

B. *Hypothyroidism.* With one of the following, despite prescribed therapy:

1. IQ of 70 or less; or

2. Growth impairment as described under the criteria in 100.02 A and B; or

3. Precocious puberty.

109.03 *Hyperparathyroidism (as documented in 109.00C).* With:

A. Repeated elevated total or ionized serum calcium; or

B. Elevated serum parathyroid hormone.

109.04 *Hypoparathyroidism or Pseudohypoparathyroidism.* With:

A. Severe recurrent tetany or convulsions which are unresponsive to prescribed therapy; or

B. Growth retardation as described under criteria in 100.02 A and B.

109.05 *Diabetes insipidus, documented by pathologic hypertonic saline or water deprivation test.* And one of the following:

A. Intracranial space-occupying lesion, before or after surgery; or

B. Unresponsiveness to Pitressin; or

C. Growth retardation as described under the criteria in 100.02 A and B; or

D. Unresponsive hypothalmic thirst center, with chronic or recurrent hypernatremia; or

E. Decreased visual fields attributable to a pituitary lesion.

109.06 *Hyperfunction of the adrenal cortex (Primary or secondary).* With:

A. Elevated urinary 17-hyroxycorticosteroids (or 17-ketogenic steroids) as documented in 109.00 C and D; and

B. Unresponsiveness to low-dose dexamethasone suppression.

109.07 *Adrenal cortical insufficiency (as documented in 109.00 C and E)* with recent, recurrent episodes of circulatory collapse.

109.08 *Juvenile diabetes mellitus (as documented in 109.00C) requiring parenteral insulin.* And one of the following, despite prescribed therapy:

A. Recent, recurrent hospitalizations with acidosis; or

B. Recent, recurrent episodes of hypoglycemia; or

C. Growth retardation as described under the criteria in 100.02 A or B; or

D. Impaired renal function as described under the criteria in 106.00ff.

109.09 *Iatrogenic hypercorticoid state.*

With chronic glucocorticoid therapy resulting in one of the following:

A. Osteoporosis; or

B. Growth retardation as described under the criteria in 100.02 A or B; or

C. Diabetes mellitus as described under the criteria in 109.08; or

D. Myopathy as described under the criteria in 111.06; or

E. Emotional disorder as described under the criteria in 112.00ff.

109.10 *Pituitary dwarfism (with documented growth hormone deficiency).* And growth impairment as described under the criteria in 100.02B.

109.11 *Adrenogenital syndrome.* With:

A. Recent, recurrent self-losing episodes despite prescribed therapy; or

B. Inadequate replacement therapy manifested by accelerated bone age and virilization, or

C. Growth impairment as described under the criteria in 100.02 A or B.

109.12 *Hypoglycemia (as documented in 109.00C).* With recent, recurrent hypoglycemic episodes producing convulsion or coma.

109.13 *Gonadal Dysgenesis (Turner's Syndrome), chromosomally proven.* Evaluate the resulting impairment under the criteria for the appropriate body system.

110.00 Multiple Body Systems

A. This section refers to those life-threatening catastrophic congenital abnormalities and other serious hereditary, congenital, or acquired disorders that usually affect two or more body systems and are expected to:

1. Result in early death or developmental attainment of less than 2 years of age as described in listing 110.08 (e.g., anencephaly or Tay-Sachs); or

2. Produce long-term, if not life-long, significant interference with age-appropriate major daily or personal care activities as described in listings 110.06 and 110.07. (Significant interference with age-appropriate activities is considered to exist where the developmental milestone age did not exceed two-thirds of the chronological age at the time of evaluation and such interference has lasted or could be expected to last at least 12 months.) See 112.00C for a discussion of developmental milestone criteria and evaluation of age-appropriate activities.

Down syndrome (except for mosaic Down syndrome, which is to be evaluated under listing 110.07) established by clinical findings, including the characteristic physical features, and laboratory evidence is considered to meet the requirement of listing 110.06 commencing at birth. Examples of disorders that should be evaluated under listing 110.07 include mosaic Down syndrome and chromosomal abnormalities other than Down syndrome, in which a pattern of multiple impairments (including mental retardation) is known to occur, phenylketonuria (PKU), fetal alcohol syndrome, and severe chronic neonatal infections such as toxoplasmosis, rubella syndrome, cytomegalic inclusion disease, and herpes encephalitis.

B. Documentation must include confirmation of a positive diagnosis by a clinical description of the usual abnormal physical findings associated with the condition and definitive laboratory tests, including chromosomal analysis, where appropriate (e.g., Down syndrome). Medical evidence that is persuasive that a positive diagnosis has been confirmed by appropriate laboratory testing,

at some time prior to evaluation, is acceptable in lieu of a copy of the actual laboratory report.

C. When multiple body system manifestations do not meet one of the established criteria of one of the listings, the combined impairments must be evaluated together to determine if they are equal in severity to a listed impairment.

110.01 Category of Impairments, Multiple Body Systems

110.06 *Down syndrome (excluding mosaic Down syndrome)* established by clinical and laboratory findings, as described in 110.00B. Consider the child disabled from birth.

110.07 *Multiple body dysfunction* due to any confirmed (see 110.00B) hereditary, congenital, or acquired condition with one of the following:

A. Persistent motor dysfunction as a result of hypotonia and/or musculoskeletal weakness, postural reaction deficit, abnormal primitive reflexes, or other neurological impairment as described in 111.00C, and with significant interference with age-appropriate major daily or personal care activities, which in an infant or young child include such activities as head control, swallowing, following, reaching, grasping, turning, sitting, crawling, walking, taking solids, feeding self; or

B. Mental impairment as described under the criteria in 112.05 or 112.12; or

C. Growth impairment as described under the criteria in 100.02A or B; or

D. Significant interference with communication due to speech, hearing, or visual impairments as described under the criteria in 102.00 and 111.09; or

E. Cardiovascular impairments as described under the criteria in 104.00; or

F. Other impairments such as, but not limited to, malnutrition, hypothyroidism, or seizures should be evaluated under the criteria in 105.08, 109.02 or 111.02 and 111.03, or the criteria for the affected body system.

110.08 *Catastrophic congenital abnormalities or disease.* With:

A. A positive diagnosis (such as anencephaly, trisomy D or E, cyclopia, etc.), generally regarded as being incompatible with extrauterine life; or

B. A positive diagnosis (such as cri du chat, Tay-Sachs Disease) wherein attainment of the growth and development level of 2 years is not expected to occur.

111.00 NEUROLOGICAL

A. *Seizure disorder* must be substantiated by at least one detailed description of a typical seizure. Report of recent documentation should include an electroencephalogram and neurological examination. Sleep EEG is preferable, especially with temporal lobe seizures. Frequency of attacks and any associated phenomena should also be substantiated.

Young children may have convulsions in association with febrile illnesses. Proper use of 111.02 and 111.03 requires that a seizure disorder be established. Although this does not exclude consideration of seizures occurring during febrile illnesses, it does require documentation of seizures during nonfebrile periods.

There is an expected delay in control of seizures when treatment is started, particularly when changes in the treatment regimen are necessary. Therefore, a seizure disorder should not be considered to meet the requirements of 111.02 or 111.03 unless it is shown that seizures have persisted more than three months after prescribed therapy began.

B. *Minor motor seizures.* Classical petit mal seizures must be documented by characteristic EEG pattern, plus information as to age at onset and frequency of clinical seizures. Myoclonic seizures, whether of the typical infantile or Lennox-gastaut variety after infancy, must also be documented by the characteristic EEG pattern plus information as to age at onset and frequency of seizures.

C. *Motor dysfunction.* As described in 111.06, motor dysfunction may be due to any neurological disorder. It may be due to static or progressive conditions involving any area of the nervous system and producing any type of neurological impairment. This may include weakness, spasticity, lack of coordination, ataxia, tremor, athetosis, or sensory loss. Documentation of motor dysfunction must include neurologic findings and description of type of neurologic abnormality (e.g., spasticity, weakness), as well as a description of the child's functional impairment (i.e., what the child is unable to do because of the abnormality). Where a diagnosis has been made, evidence should be included for substantiation of the diagnosis (e.g., blood chemistries and muscle biopsy reports), wherever applicable.

D. *Impairment of communication.* The documentation should include a description of a recent comprehensive evaluation, including all areas of affective and effective communication, performed by a qualified professional.

111.01 Category of Impairment, Neurological

111.02 *Major motor seizure disorder.*

A. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of more than one major motor seizure per month despite at least three months of prescribed treatment. With:

1. Daytime episodes (loss of consciousness and convulsive seizures); or

2. Nocturnal episodes manifesting residuals which interfere with activity during the day.

B. *Major motor seizures.* In a child with an established seizure disorder, the occurrence of a least one major motor seizure in the year prior to application despite at least

three months of prescribed treatment. And one of the following:

1. IQ of 70 or less; or

2. Significant interference with communication due to speech, hearing, or visual defect; or

3. Significant emotional disorder; or

4. Where significant adverse effects of medication interfere with major daily activities.

111.03 *Minor motor seizure disorder.* In a child with an established seizure disorder, the occurrence of more than one minor motor seizure per week, with alteration of awareness or loss of consciousness, despite at least three months of prescribed treatment.

111.05 *Brain tumors. A. Malignant* gliomas (astrocytoma—Grades III and IV, glioblastoma multiforme), medulloblastoma, ependymoblastoma, primary sarcoma or brain stem gliomas; or

B. Evaluate other brain tumors under the criteria for the resulting neurological impairment.

111.06 *Motor dysfunction (due to any neurological disorder).* Persistent disorganization or deficit of motor function for age involving two extremities, which (despite prescribed therapy) interferes with age-appropriate major daily activities and results in disruption of:

A. Fine and gross movements; or

B. Gait and station.

111.07 *Cerebral palsy.* With:

A. Motor dysfunction meeting the requirements of 111.06 or 101.03; or

B. Less severe motor dysfunction (but more than slight) and one of the following:

1. IQ of 70 or less; or

2. Seizure disorder, with at least one major motor seizure in the year prior to application; or

3. Significant interference with communication due to speech, hearing or visual defect; or

4. Significant emotional disorder.

111.08 *Meningomyelocele (and related disorders).* With one of the following despite prescribed treatment:

A. Motor dysfunction meeting the requirements of §101.03 or §111.06; or

B. Less severe motor dysfunction (but more than slight), and:

1. Urinary or fecal incontinence when inappropriate for age; or

2. IQ of 70 or less; or

C. Four extremity involvement; or

D. Noncompensated hydrocephalus producing interference with mental or motor developmental progression.

111.09 *Communication impairment, associated with documented neurological disorder.* And one of the following:

A. Documented speech deficit which significantly affects the clarity and content of the speech; or

B. Documented comprehension deficit resulting in ineffective verbal communication for age; or

C. Impairment of hearing as described under the criteria in 102.08.

112.00 Mental Disorders

A. *Introduction:* The structure of the mental disorders listings for children under age 18 parallels the structure for the mental disorders listings for adults but is modified to reflect the presentation of mental disorders in children. The listings for mental disorders in children are arranged in 11 diagnostic categories: Organic mental disorders (112.02); schizophrenic, delusional (paranoid), schizoaffective, and other psychotic disorders (112.03); mood disorders (112.04); mental retardation (112.05); anxiety disorders (112.06); somatoform, eating, and tic disorders (112.07); personality disorders (112.08); psychoactive substance dependence disorders (112.09); autistic disorder and other pervasive developmental disorders (112.10); attention deficit hyperactivity disorder (112.11); and developmental and emotional disorders of newborn and younger infants (112.12).

There are significant differences between the listings for adults and the listings for children. There are disorders found in children that have no real analogy in adults; hence, the differences in the diagnostic categories for children. The presentation of mental disorders in children, particularly the very young child, may be subtle and of a character different from the signs and symptoms found in adults. For example, findings such as separation anxiety, failure to mold or bond with the parents, or withdrawal may serve as findings comparable to findings that mark mental disorders in adults. The activities appropriate to children, such as learning, growing, playing, maturing, and school adjustment, are also different from the activities appropriate to the adult and vary widely in the different childhood stages.

Each listing begins with an introductory statement that describes the disorder or disorders addressed by the listing. This is followed (except in listings 112.05 and 112.12) by medical findings (paragraph A criteria), which, if satisfied, lead to an assessment of impairment-related functional limitations (paragraph B criteria). An individual will be found to have a listed impairment when the criteria of both paragraphs A and B of the listed impairment are satisfied.

The purpose of the criteria in paragraph A is to substantiate medically the presence of a particular mental disorder. Specific symptoms and signs under any of the listings 112.02 through 112.12 cannot be considered in isolation from the description of the mental disorder contained at the beginning of each listing category. Impairments should be analyzed or reviewed under the mental category(ies) indicated by the medical findings.

Paragraph A of the listings is a composite of medical findings which are used to substantiate the existence of a disorder and may or may not be appropriate for children at specific developmental stages. However, a range of medical findings is included in the listings so that no age group is excluded. For example, in listing 112.02A7, emotional lability and crying would be inappropriate criteria to apply to older infants and toddlers, age 1 to attainment of age 3; whereas in 112.02A1, developmental arrest, delay, or regression are appropriate criteria for older infants and toddlers. Whenever the adjudicator decides that the requirements of paragraph A of a particular mental listing are satisfied, then that listing should be applied regardless of the age of the child to be evaluated.

The purpose of the paragraph B criteria is to describe impairment-related functional limitations which are applicable to children. Standardized tests of social or cognitive function and adaptive behavior are frequently available and appropriate for the evaluation of children and, thus, such tests are included in the paragraph B functional parameters. The functional restrictions in paragraph B must be the result of the mental disorder which is manifested by the medical findings in paragraph A.

We have not included separate C criteria for listings 112.03 and 112.06, as are found in the adult listings, because for the most part we do not believe that categories like residual schizophrenia or agoraphobia are commonly found in children. However, in unusual cases where these disorders are found in children and are comparable to the severity and duration found in adults, the adult 12.03C and 12.06C criteria may be used for evaluation of the cases.

The structure of the listings for Mental Retardation (112.05) and Developmental and Emotional Disorders of Newborn and Younger Infants (112.12) is different from that of the other mental disorders. Listing 112.05 (Mental Retardation) contains six sets of criteria, any one of which, if satisfied, will result in a finding that the child's impairment meets the listing. Listing 112.12 (Developmental and Emotional Disorders of Newborn and Younger Infants) contains five criteria, any one of which, if satisfied, will result in a finding that the infant's impairment meets the listing.

It must be remembered that these listings are only examples of common mental disorders that are severe enough to find a child disabled. When a child has a medically determinable impairment that is not listed, an impairment that does not meet the requirements of a listing, or a combination of impairments no one of which meets the requirements of a listing, we will make a determination whether the child's impairment(s) is medically or functionally equivalent in severity to the criteria of a listing. (See §§404.1526, 416.926, and 416.926a.) This determination can be especially important in older infants and toddlers (age 1 to attainment of age 3), who may be too young for identification of a specific diagnosis, yet demonstrate serious functional limitations. Therefore, the determination of equivalency is necessary to the evaluation of any child's case when the child does not have an impairment that meets a listing.

B. *Need for Medical Evidence:* The existence of a medically determinable impairment of the required duration must be established by medical evidence consisting of symptoms, signs, and laboratory findings (including psychological or developmental test findings). Symptoms are complaints presented by the child. Psychiatric signs are medically demonstrable phenomena which indicate specific abnormalities of behavior, affect, thought, memory, orientation, development, and contact with reality, as described by an appropriate medical source. Symptoms and signs generally cluster together to constitute recognizable mental disorders described in paragraph A of the listings. These findings may be intermittent or continuous depending on the nature of the disorder.

C. *Assessment of Severity:* In childhood cases, as with adults, severity is measured according to the functional limitations imposed by the medically determinable mental impairment. However, the range of functions used to assess impairment severity for children varies at different stages of maturation. The functional areas that we consider are: Motor function; cognitive/communicative function; social function; personal function; and concentration, persistence, or pace. In most functional areas, there are two alternative methods of documenting the required level of severity: (1) Use of standardized tests alone, where appropriate test instruments are available, and (2) use of other medical findings. (See 112.00D for explanation of these documentation requirements.) The use of standardized tests is the preferred method of documentation if such tests are available.

Newborn and younger infants (birth to attainment of age 1) have not developed sufficient personality differentiation to permit formulation of appropriate diagnoses. We have, therefore, assigned listing 112.12 for Developmental and Emotional Disorders of Newborn and Younger Infants for the evaluation of mental disorders of such children. Severity of these disorders is based on measures of development in motor, cognitive/communicative, and social functions. When older infants and toddlers (age 1 to attainment of age 3) do not clearly satisfy the paragraph A criteria of any listing because of insufficient developmental differentiation, they must be evaluated under the rules for equivalency. The principles for assessing the

severity of impairment in such children, described in the following paragraphs, must be employed.

In defining the severity of functional limitations, two different sets of paragraph B criteria corresponding to two separate age groupings have been established, in addition to listing 112.12, which is for children who have not attained age 1. These age groups are: older infants and toddlers (age 1 to attainment of age 3) and children (age 3 to attainment of age 18). However, the discussion below in 112.00C1, 2, 3, and 4, on the age-appropriate areas of function, is broken down into four age groupings: older infants and toddlers (age 1 to attainment of age 3), preschool children (age 3 to attainment of age 6), primary school children (age 6 to attainment of age 12), and adolescents (age 12 to attainment of age 18). This was done to provide specific guidance on the age group variances in disease manifestations and methods of evaluation.

Where ''marked'' is used as a standard for measuring the degree of limitation it means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired, or even when only one is impaired, as long as the degree of limitation is such as to interfere seriously with the ability to function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis. When standardized tests are used as the measure of functional parameters, a valid score that is two standard deviations below the norm for the test will be considered a marked restriction.

1. *Older infants and toddlers (age 1 to attainment of age 3).* In this age group, impairment severity is assessed in three areas: (a) Motor development, (b) cognitive/communicative function, and (c) social function.

a. *Motor development.* Much of what we can discern about mental function in these children frequently comes from observation of the degree of development of fine and gross motor function. Developmental delay, as measured by a good developmental milestone history confirmed by medical examination, is critical. This information will ordinarily be available in the existing medical evidence from the claimant's treating sources and other medical sources, supplemented by information from nonmedical sources, such as parents, who have observed the child and can provide pertinent historical information. It may also be available from standardized testing. If the delay is such that the older infant or toddler has not achieved motor development generally acquired by children no more than one-half the child's chronological age, the criteria are satisfied.

b. *Cognitive/communicative function.* Cognitive/communicative function is measured using one of several standardized infant scales. Appropriate tests for the measure of such function are discussed in 112.00D. Care should be taken to avoid reliance on screening devices, which are not generally considered to be sufficiently reliable instruments, although such devices may provide some relevant data; however, there will be cases in which the results of such tests show such severe abnormalities that further testing will be unnecessary.

For older infants and toddlers, alternative criteria covering disruption in communication as measured by their capacity to use simple verbal and nonverbal structures to communicate basic needs are provided.

c. *Social function.* Social function in older infants and toddlers is measured in terms of the development of relatedness to people (e.g., bonding and stranger anxiety) and attachment to animate or inanimate objects. Criteria are provided that use standard social maturity scales or alternative criteria that describe marked impairment in socialization.

2. *Preschool children (age 3 to attainment of age 6).* For the age groups including preschool children through adolescence, the functional areas used to measure severity are: (a) Cognitive/communicative function, (b) social function, (c) personal function, and (d) deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner. After 36 months, motor function is no longer felt to be a primary determinant of mental function, although, of course, any motor abnormalities should be documented and evaluated.

a. *Cognitive/communicative function.* In the preschool years and beyond, cognitive function can be measured by standardized tests of intelligence, although the appropriate instrument may vary with age. A primary criterion for limited cognitive function is a valid verbal, performance, or full scale IQ of 70 or less. The listings also provide alternative criteria, consisting of tests of language development or bizarre speech patterns.

b. *Social function.* Social functioning refers to a child's capacity to form and maintain relationships with parents, other adults, and peers. Social functioning includes the ability to get along with others (e.g., family members, neighborhood friends, classmates, teachers). Impaired social functioning may be caused by inappropriate externalized actions (e.g., running away, physical aggression—but not self-injurious actions, which are evaluated in the personal area of functioning), or inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Its severity must be documented in terms of intensity, frequency, and duration, and shown to be beyond what might be reasonably expected for age. Strength in social functioning may be documented by such things

as the child's ability to respond to and initiate social interaction with others, to sustain relationships, and to participate in group activities. Cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity, appropriate to a child's age, also need to be considered. Social functioning in play and school may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches) or cooperative behaviors involving other children. Social functioning is observed not only at home but also in preschool programs.

c. *Personal function.* Personal functioning in preschool children pertains to self-care; i.e., personal needs, health, and safety (feeding, dressing, toileting, bathing; maintaining personal hygiene, proper nutrition, sleep, health habits; adhering to medication or therapy regimens; following safety precautions). Development of self-care skills is measured in terms of the child's increasing ability to help himself/herself and to cooperate with others in taking care of these needs. Impaired ability in this area is manifested by failure to develop such skills, failure to use them, or self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by a careful description of the full range of self-care activities. These activities are often observed not only at home but also in preschool programs.

d. *Concentration, persistence, or pace.* This function may be measured through observations of the child in the course of standardized testing and in the course of play.

3. *Primary school children (age 6 to attainment of age 12).* The measures of function here are similar to those for preschool-age children except that the test instruments may change and the capacity to function in the school setting is supplemental information. Standardized measures of academic achievement, e.g., Wide Range Achievement Test-Revised, Peabody Individual Achievement Test, etc., may be helpful in assessing cognitive impairment. Problems in social functioning, especially in the area of peer relationships, are often observed firsthand by teachers and school nurses. As described in 112.00D, *Documentation,* school records are an excellent source of information concerning function and standardized testing and should always be sought for school-age children.

As it applies to primary school children, the intent of the functional criterion described in paragraph B2d, i.e., deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner, is to identify the child who cannot adequately function in primary school because of a mental impairment. Although grades and the need for special education placement are relevant factors which must be considered in reaching a decision under paragraph B2d, they are not conclusive. There is too much variability from school district to school district in the expected level of grading and in the criteria for special education placement to justify reliance solely on these factors.

4. *Adolescents (age 12 to attainment of age 18).* Functional criteria parallel to those for primary school children (cognitive/communicative; social; personal; and concentration, persistence, or pace) are the measures of severity for this age group. Testing instruments appropriate to adolescents should be used where indicated. Comparable findings of disruption of social function must consider the capacity to form appropriate, stable, and lasting relationships. If information is available about cooperative working relationships in school or at part-time or full-time work, or about the ability to work as a member of a group, it should be considered when assessing the child's social functioning. Markedly impoverished social contact, isolation, withdrawal, and inappropriate or bizarre behavior under the stress of socializing with others also constitute comparable findings. (Note that self-injurious actions are evaluated in the personal area of functioning.)

a. Personal functioning in adolescents pertains to self-care. It is measured in the same terms as for younger children, the focus, however, being on the adolescent's ability to take care of his or her own personal needs, health, and safety without assistance. Impaired ability in this area is manifested by failure to take care of these needs or by self-injurious actions. This function may be documented by a standardized test of adaptive behavior or by careful descriptions of the full range of self-care activities.

b. In adolescents, the intent of the functional criterion described in paragraph B2d is the same as in primary school children, However, other evidence of this functional impairment may also be available, such as from evidence of the child's performance in work or work-like settings.

D. *Documentation:* The presence of a mental disorder in a child must be documented on the basis of reports from acceptable sources of medical evidence. See §§404.1513 and 416.913. Descriptions of functional limitations may be available from these sources, either in the form of standardized test results or in other medical findings supplied by the sources, or both. (Medical findings consist of symptoms, signs, and laboratory findings.) Whenever possible, a medical source's findings should reflect the medical source's consideration of information from parents or other concerned individuals who are aware of the child's activities of daily living, social functioning, and ability to adapt to different settings and expectations, as well as the medical source's findings and observations on examination, consistent with standard clinical practice. As necessary, information

from nonmedical sources, such as parents, should also be used to supplement the record of the child's functioning to establish the consistency of the medical evidence and longitudinality of impairment severity.

For some newborn and younger infants, it may be very difficult to document the presence or severity of a mental disorder. Therefore, with the exception of some genetic diseases and catastrophic congenital anomalies, it may be necessary to defer making a disability decision until the child attains 3 months of age in order to obtain adequate observation of behavior or affect. See, also, 110.00 of this part. This period could be extended in cases of premature infants depending on the degree of prematurity and the adequacy of documentation of their developmental and emotional status.

For infants and toddlers, programs of early intervention involving occupational, physical, and speech therapists, nurses, social workers, and special educators, are a rich source of data. They can provide the developmental milestone evaluations and records on the fine and gross motor functioning of these children. This information is valuable and can complement the medical examination by a physician or psychologist. A report of an interdisciplinary team that contains the evaluation and signature of an acceptable medical source is considered acceptable medical evidence rather than supplemental data.

In children with mental disorders, particularly those requiring special placement, school records are a rich source of data, and the required reevaluations at specified time periods can provide the longitudinal data needed to trace impairment progression over time.

In some cases where the treating sources lack expertise in dealing with mental disorders of children, it may be necessary to obtain evidence from a psychiatrist, psychologist, or pediatrician with experience and skill in the diagnosis and treatment of mental disorders as they appear in children. In these cases, however, every reasonable effort must be made to obtain the records of the treating sources, since these records will help establish a longitudinal picture that cannot be established through a single purchased examination.

A reference to standardized psychological testing indicates the use of a psychological test that has appropriate characteristics of validity, reliability, and norms, administered individually by psychologist, psychiatrist, pediatrician, or other physician specialist qualified by training and experience to perform such an evaluation. Psychological tests are best considered as sets of tasks or questions designed to elicit particular behaviors when presented in a standardized manner.

The salient characteristics of a good test are: (1) Validity, i.e., the test measures what it is supposed to measure, as determined by appropriate methods; (2) reliability, i.e., the consistency of results obtained over time with the same test and the same individual; and (3) appropriate normative data, i.e., individual test scores must be comparable to test data from other individuals or groups of a similar nature, representative of that population. In considering the validity of a test result, any discrepancies between formal test results and the child's customary behavior and daily activities should be duly noted and resolved.

Tests meeting the above requirements are acceptable for the determination of the conditions contained in these listings. The psychologist, psychiatrist, pediatrician, or other physician specialist administering the test must have a sound technical and professional understanding of the test and be able to evaluate the research documentation related to the intended application of the test.

Identical IQ scores obtained from different tests do not always reflect a similar degree of intellectual functioning. The IQ scores in listing 112.05 reflect values from tests of general intelligence that have a mean of 100 and a standard deviation of 15, e.g., the Wechsler series and the Revised Stanford-Binet scales. Thus, IQ's below 60 reflect a level of intellectual functioning below 99.5 percent of the general population, and IQ's of 70 and below are characteristic of approximately the lowest 2 percent of the general population. IQ's obtained from standardized tests that deviate significantly from a mean of 100 and standard deviation of 15 require conversion to the corresponding percentile rank in the general population so that the actual degree of impairment reflected by the IQ scores can be determined. In cases where more than one IQ is customarily derived from the test administered, e.g., where verbal, performance, and full scale IQ's are provided, as on the Wechsler series, the lowest of these is used in conjunction with listing 112.05.

IQ test results must also be sufficiently current for accurate assessment under 112.05. Generally, the results of IQ tests tend to stabilize by the age of 16. Therefore, IQ test results obtained at age 16 or older should be viewed as a valid indication of the child's current status, provided they are compatible with the child's current behavior. IQ test results obtained between ages 7 and 16 should be considered current for 4 years when the tested IQ is less than 40, and for 2 years when the IQ is 40 or above. IQ test results obtained before age 7 are current for 2 years if the tested IQ is less than 40 and 1 year if at 40 or above.

Standardized intelligence test results are essential to the adjudication of all cases of mental retardation that are not covered under the provisions of listings 112.05A, 112.05B, and 112.05F. Listings 112.05A, 112.05B, and 112.05F may be the bases for adjudicating

cases where the results of standardized intelligence tests are unavailable, e.g., where the child's young age or condition precludes formal standardized testing.

In conjunction with clinical examinations, sources may report the results of screening tests, i.e., tests used for gross determination of level of functioning. These tests do not have high validity and reliability and generally are not considered appropriate primary evidence for disability determinations. These screening instruments may be useful in uncovering potentially serious impairments, but generally must be supplemented by the use of formal, standardized psychological testing for the purposes of a disability determination, unless the determination is to be made on the basis of findings other than psychological test data; however, there will be cases in which the results of screening tests show such obvious abnormalities that further testing will clearly be unnecessary.

Where reference is made to developmental milestones, this is defined as the attainment of particular mental or motor skills at an age-appropriate level, i.e., the skills achieved by an infant or toddler sequentially and within a given time period in the motor and manipulative areas, in general understanding and social behavior, in self-feeding, dressing, and toilet training, and in language. This is sometimes expressed as a developmental quotient (DQ), the relation between developmental age and chronological age as determined by specific standardized measurements and observations. Such tests include, but are not limited to, the Cattell Infant Intelligence Scale, the Bayley Scales of Infant Development, and the Revised Stanford-Binet. Formal tests of the attainment of developmental milestones are generally used in the clinical setting for determination of the developmental status of infants and toddlers.

Formal psychological tests of cognitive functioning are generally in use for preschool children, for primary school children, and for adolescents except for those instances noted below.

Exceptions to formal standardized psychological testing may be considered when a psychologist, psychiatrist, pediatrician, or other physician specialist who is qualified by training and experience to perform such an evaluation is not readily available. In such instances, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination.

Exceptions may also be considered in the case of ethnic/cultural minorities where the native language or culture is not principally English-speaking. In such instances, psychological tests that are culture-free, such as the Leiter International Performance Scale or the Scale of Multi-Culture Pluralistic Assessment (SOMPA) may be substituted for the standardized tests described above. Any required tests must be administered in the child's principal language. When this is not possible, appropriate medical, historical, social, and other information must be reviewed in arriving at a determination. Furthermore, in evaluating mental impairments in children from a different culture, the best indicator of severity is often the level of adaptive functioning and how the child performs activities of daily living and social functioning.

Neuropsychological testing refers to the administration of standardized tests that are reliable and valid with respect to assessing impairment in brain functioning. It is intended that the psychologist or psychiatrist using these tests will be able to evaluate the following functions: Attention/concentration, problem-solving, language, memory, motor, visual-motor and visual-perceptual, laterality, and general intelligence (if not previously obtained).

E. *Effect of Hospitalization or Residential Placement:* As with adults, children with mental disorders may be placed in a variety of structured settings outside the home as part of their treatment. Such settings include, but are not limited to, psychiatric hospitals, developmental disabilities facilities, residential treatment centers and schools, community-based group homes, and workshop facilities. The reduced mental demands of such structured settings may attenuate overt symptomatology and superficially make the child's level of adaptive functioning appear better than it is. Therefore, the capacity of the child to function outside highly structured settings must be considered in evaluating impairment severity. This is done by determining the degree to which the child can function (based upon age-appropriate expectations) independently, appropriately, effectively, and on a sustained basis outside the highly structured setting.

On the other hand, there may be a variety of causes for placement of a child in a structured setting which may or may not be directly related to impairment severity and functional ability. Placement in a structured setting in and of itself does not equate with a finding of disability. The severity of the impairment must be compared with the requirements of the appropriate listing.

F. *Effects of Medication:* Attention must be given to the effect of medication on the child's signs, symptoms, and ability to function. While psychoactive medications may control certain primary manifestations of a mental disorder, e.g., hallucinations, impaired attention, restlessness, or hyperactivity, such treatment may or may not affect the functional limitations imposed by the mental disorder. In cases where overt symptomatology is attenuated by the

psychoactive medications, particular attention must be focused on the functional limitations which may persist. These functional limitations must be considered in assessing impairment severity.

Psychotropic medicines used in the treatment of some mental illnesses may cause drowsiness, blunted affect, or other side effects involving other body systems. Such side effects must be considered in evaluating overall impairment severity.

112.01 Category of Impairments, Mental

112.02 *Organic Mental Disorders:* Abnormalities in perception, cognition, affect, or behavior associated with dysfunction of the brain. The history and physical examination or laboratory tests, including psychological or neuropsychological tests, demonstrate or support the presence of an organic factor judged to be etiologically related to the abnormal mental state and associated deficit or loss of specific cognitive abilities, or affective changes, or loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence of at least one of the following:

1. Developmental arrest, delay or regression; or

2. Disorientation to time and place; or

3. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or

4. Perceptual or thinking disturbance (e.g., hallucinations, delusions, illusions, or paranoid thinking); or

5. Disturbance in personality (e.g., apathy, hostility); or

6. Disturbance in mood (e.g., mania, depression); or

7. Emotional lability (e.g., sudden crying); or

8. Impairment of impulse control (e.g., disinhibited social behavior, explosive temper outbursts); or

9. Impairment of cognitive function, as measured by clinically timely standardized psychological testing; or

10. Disturbance of concentration, attention, or judgment;

AND

B. Select the appropriate age group to evaluate the severity of the impairment:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the following:

a. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings (see 112.00C); or

b. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of equivalent cognitive/communicative abnormality, such as the inability to use simple verbal or nonverbal behavior to communicate basic needs or concepts; or

c. Social function at a level generally acquired by children no more than one-half the child's chronological age, documented by:

(1) An appropriate standardized test; or

(2) Other medical findings of an equivalent abnormality of social functioning, exemplified by serious inability to achieve age-appropriate autonomy as manifested by excessive clinging or extreme separation anxiety; or

d. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by a., b., or c., as measured by an appropriate standardized test or other appropriate medical findings.

2. For children (age 3 to attainment of age 18), resulting in at least two of the following:

a. Marked impairment in age-appropriate cognitive/communicative function, documented by medical findings (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized psychlogical tests, or for children under age 6, by appropriate tests of language and communication; or

b. Marked impairment in age-appropriate social functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, the results of appropriate standardized tests; or

c. Marked impairment in age-appropriate personal functioning, documented by history and medical findings (including consideration of information from parents or other individuals who have knowledge of the child, when such information is needed and available) and including, if necessary, appropriate standardized tests; or

d. Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner.

112.03 *Schizophrenic, Delusional (Paranoid), Schizoaffective, and Other Psychotic Disorders:* Onset of psychotic features, characterized by a marked disturbance of thinking, feeling, and behavior, with deterioration from a previous level of functioning or failure to achieve the expected level of social functioning.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, for at least 6 months, either continuous or intermittent, of one or more of the following:

1. Delusions or hallucinations; or

2. Catatonic, bizarre, or other grossly disorganized behavior; or

3. Incoherence, loosening of associations, illogical thinking, or poverty of content of speech; or

4. Flat, blunt, or inappropriate affect; or

5. Emotional withdrawal, apathy, or isolation;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.04 *Mood Disorders:* Characterized by a disturbance of mood (referring to a prolonged emotion that colors the whole psychic life, generally involving either depression or elation), accompanied by a full or partial manic or depressive syndrome.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following:

1. Major depressive syndrome, characterized by at least five of the following, which must include either depressed or irritable mood or markedly diminished interest or pleasure:

a. Depressed or irritable mood; or

b. Markedly diminished interest or pleasure in almost all activities; or

c. Appetite or weight increase or decrease, or failure to make expected weight gains; or

d. Sleep disturbance; or

e. Psychomotor agitation or retardation; or

f. Fatigue or loss of energy; or

g. Feelings of worthlessness or guilt; or

h. Difficulty thinking or concentrating; or

i. Suicidal thoughts or acts; or

j. Hallucinations, delusions, or paranoid thinking;

OR

2. Manic syndrome, characterized by elevated, expansive, or irritable mood, and at least three of the following:

a. Increased activity or psychomotor agitation; or

b. Increased talkativeness or pressure of speech; or

c. Flight of ideas or subjectively experienced racing thoughts; or

d. Inflated self-esteem or grandiosity; or

e. Decreased need for sleep; or

f. Easy distractibility; or

g. Involvement in activities that have a high potential of painful consequences which are not recognized; or

h. Hallucinations, delusions, or paranoid thinking;

OR

3. Bipolar or cyclothymic syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently or most recently characterized by the full or partial symptomatic picture of either or both syndromes);

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.05 *Mental Retardation:* Characterized by significantly subaverage general intellectual functioning with deficits in adaptive functioning.

The required level of severity for this disorder is met when the requirements in A, B, C, D, E, or F are satisfied.

A. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02;

OR

B. Mental incapacity evidenced by dependence upon others for personal needs (grossly in excess of age-appropriate dependence) and inability to follow directions such that the use of standardized measures of intellectual functioning is precluded;

OR

C. A valid verbal, performance, or full scale IQ of 59 or less;

OR

D. A valid verbal, performance, or full scale IQ of 60 through 70 and a physical or other mental impairment imposing additional and significant limitation of function;

OR

E. A valid verbal, performance, or full scale IQ of 60 through 70 and:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in either paragraphs B1a or B1c of 112.02; or

2. For children (age 3 to attainment of age 18), resulting in at least one of paragraphs B2b or B2c or B2d of 112.02;

OR

F. Select the appropriate age group:

1. For older infants and toddlers (age 1 to attainment of age 3), resulting in attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in paragraph B1b of 112.02, and a physical or other mental impairment imposing additional and significant limitations of function;

OR

2. For children (age 3 to attainment of age 18), resulting in the satisfaction of 112.02B2a, and a physical or other mental impairment imposing additional and significant limitations of function.

112.06 *Anxiety Disorders:* In these disorders, anxiety is either the predominant disturbance or is experienced if the individual attempts to master symptoms, e.g., confronting the dreaded object or situation in a phobic disorder, attempting to go to school in a separation anxiety disorder, resisting the obsessions or compulsions in an obsessive compulsive disorder, or confronting strangers or peers in avoidant disorders.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least one of the following:

1. Excessive anxiety manifested when the child is separated, or separation is threatened, from a parent or parent surrogate; or

2. Excessive and persistent avoidance of strangers; or

3. Persistent unrealistic or excessive anxiety and worry (apprehensive expectation), accompanied by motor tension, autonomic hyperactivity, or vigilance and scanning; or

4. A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

5. Recurrent severe panic attacks, manifested by a sudden unpredictable onset of intense apprehension, fear, or terror, often with a sense of impending doom, occurring on the average of at least once a week; or

6. Recurrent obsessions or compulsions which are a source of marked distress; or

7. Recurrent and intrusive recollections of a traumatic experience, including dreams, which are a source of marked distress;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.07 *Somatoform, Eating, and Tic Disorders:* Manifested by physical symptoms for which there are no demonstrable organic findings or known physiologic mechanisms; or eating or tic disorders with physical manifestations.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of one of the following:

1. An unrealistic fear and perception of fatness despite being underweight, and persistent refusal to maintain a body weight which is greater than 85 percent of the average weight for height and age, as shown in the most recent edition of the *Nelson Textbook of Pediatrics,* Richard E. Behrman and Victor C. Vaughan, III, editors, Philadelphia: W. B. Saunders Company; or

2. Persistent and recurrent involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups with multiple vocal tics; or

3. Persistent nonorganic disturbance of one of the following:

a. Vision; or

b. Speech; or

c. Hearing; or

d. Use of a limb; or

e. Movement and its control (e.g., coordination disturbance, psychogenic seizures); or

f. Sensation (diminished or heightened); or

g. Digestion or elimination; or

4. Preoccupation with a belief that one has a serious disease or injury;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.08 *Personality Disorders:* Manifested by pervasive, inflexible, and maladaptive personality traits, which are typical of the child's long-term functioning and not limited to discrete episodes of illness.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Deeply ingrained, maladaptive patterns of behavior, associated with one of the following:

1. Seclusiveness or autistic thinking; or

2. Pathologically inappropriate suspiciousness or hostility; or

3. Oddities of thought, perception, speech, and behavior; or

4. Persistent disturbances of mood or affect; or

5. Pathological dependence, passivity, or aggressiveness; or

6. Intense and unstable interpersonal relationships and impulsive and exploitative behavior; or

7. Pathological perfectionism and inflexibility;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.09 *Psychoactive Substance Dependence Disorders:* Manifested by a cluster of cognitive, behavioral, and physiologic symptoms that indicate impaired control of psychoactive substance use with continued use of the substance despite adverse consequences.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of at least four of the following:

1. Substance taken in larger amounts or over a longer period than intended and a great deal of time is spent in recovering from its effects; or

2. Two or more unsuccessful efforts to cut down or control use; or

3. Frequent intoxication or withdrawal symptoms interfering with major role obligations; or

4. Continued use despite persistent or recurring social, psychological, or physical problems; or

5. Tolerance, as characterized by the requirement for markedly increased amounts of substance in order to achieve intoxication; or

6. Substance taken to relieve or avoid withdrawal symptoms;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.10 *Autistic Disorder and Other Pervasive Developmental Disorders:* Characterized by qualitative deficits in the development of reciprocal social interaction, in the development of verbal and nonverbal communication skills, and in imaginative activity. Often, there is a markedly restricted repertoire of activities and interests, which frequently are stereotyped and repetitive.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of the following:

1. For autistic disorder, all of the following:

a. Qualitative deficits in the development of reciprocal social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity; and

c. Markedly restricted repertoire of activities and interests;

OR

2. For pervasive developmental disorders, both of the following:

a. Qualitative deficits in the development of social interaction; and

b. Qualitative deficits in verbal and nonverbal communication and in imaginative activity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraphs B2 of 112.02.

112.11 *Attention Deficit Hyperactivity Disorder:* Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied.

A. Medically documented findings of all three of the following:

1. Marked inattention; and

2. Marked impulsiveness; and

3. Marked hyperactivity;

AND

B. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

112.12 *Developmental and Emotional Disorders of Newborn and Younger Infants (Birth to attainment of age 1):* Developmental or emotional disorders of infancy are evidenced by a deficit or lag in the areas of motor, cognitive/communicative, or social functioning. These disorders may be related either to organic or to functional factors or to a combination of these factors.

The required level of severity for these disorders is met when the requirements of A, B, C, D, or E are satisfied.

A. Cognitive/communicative functioning generally acquired by children no more than one-half the child's chronological age, as documented by appropriate medical findings (e.g., in infants 0–6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking swallowing, or chewing) including, if necessary, a standardized test;

OR

B. Motor development generally acquired by children no more than one-half the child's

chronological age, documented by appropriate medical findings, including if necessary, a standardized test;

OR

C. Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to one of the following:

1. Visual stimulation; or
2. Auditory stimulation; or
3. Tactile stimulation;

OR

D. Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:

1. Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); or
2. Failure by 9 months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or
3. Failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age;

OR

E. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social), documented by appropriate medical findings, including if necessary, standardized testing.

113.00 Neoplastic Diseases, Malignant

A. *Introduction*. Determination of disability in the growing and developing child with a malignant neoplastic disease is based upon the combined effects of:

1. The pathophysiology, histology, and natural history of the tumor; and
2. The effects of the currently employed aggressive multimodal therapeutic regimens.

Combinations of surgery, radiation, and chemotherapy or prolonged therapeutic schedules impart significant additional morbidity to the child during the period of greatest risk from the tumor itself. This period of highest risk and greatest therapeutically-induced morbidity defines the limits of disability for most of childhood neoplastic disease.

B. *Documentation*. The diagnosis of neoplasm should be established on the basis of symptoms, signs, and laboratory findings. The site of the primary, recurrent, and metastatic lesion must be specified in all cases of malignant neoplastic diseases. If an operative procedure has been performed, the evidence should include a copy of the operative note and the report of the gross and microscopic examination of the surgical specimen, along with all pertinent laboratory and X-ray reports. The evidence should also include a recent report directed especially at describing whether there is evidence of local or regional recurrence, soft part or skeletal metastases, and significant post therapeutic residuals.

C. *Malignant solid tumors*, as listed under 113.03, include the histiocytosis syndromes except for solitary eosinophilic granuloma. Thus, 113.03 should not be used for evaluating brain tumors (see 111.05) or thyroid tumors, which must be evaluated on the basis of whether they are controlled by prescribed therapy.

D. *Duration of disability* from malignant neoplastic tumors is included in 113.02 and 113.03. Following the time periods designated in these sections, a documented diagnosis itself is no longer sufficient to establish a severe impairment. The severity of a remaining impairment must be evaluated on the basis of the medical evidence.

113.01 Category of Impairments, Neoplastic Diseases—Malignant

113.02 *Lymphoreticular malignant neoplasms.*

A. Hodgkin's disease with progressive disease not controlled by prescribed therapy; or

B. Non-Hodgkin's lymphoma. Consider under a disability:

1. For 2½ years from time of initial diagnosis; or
2. For 2½ years from time of recurrence of active disease.

113.03 *Malignant solid tumors.* Consider under a diability:

A. For 2 years from the time of initial diagnosis; or

B. For 2 years from the time of recurrence of active disease.

113.04 *Neuroblastoma*. With one of the following:

A. Extension across the midline; or
B. Distant metastases; or
C. Recurrence; or
D. Onset at age 1 year or older.

113.05 *Retinoblastoma.* With one of the following:

A. Bilateral involvement; or
B. Metastases; or
C. Extension beyond the orbit; or
D. Recurrence.

114.00 Immune System

A. Listed disorders include impairments involving deficiency of one or more components of the immune system (i.e., antibody-producing B cells; a number of different types of cells associated with cell-mediated immunity including T-lymphocytes, macrophages and monocytes; and components of the complement system).

B. Dysregulation of the immune system may result in the development of a connective tissue disorder. Connective tissue disorders include several chronic multisystem disorders that differ in their clinical manifestation, course, and outcome. These disorders are described in part A, 14.00B.

Some of the features of connective tissue disorders in children may differ from the features in adults. When the clinical features

are the same as that seen in adults, the principles and concepts in part A, 14.00B apply.

The documentation needed to establish the existence of a connective tissue disorder is medical history, physical examination, selected laboratory studies, medically acceptable imaging techniques and, in some instances, tissue biopsy. However, the Social Security Administration will not purchase diagnostic tests or procedures that may involve significant risk, such as biopsies or angiograms. Generally, the existing medical evidence will contain this information.

In addition to the limitations caused by the connective tissue disorder *per se,* the chronic adverse effects of treatment (e.g., corticosteroid-related ischemic necrosis of bone) may result in functional loss.

A longitudinal clinical record of at least 3 months demonstrating active disease despite prescribed treatment during this period with the expectation that the disease will remain active for 12 months is necessary for assessment of severity and duration of impairment.

In children the impairment may affect growth, development, attainment of age-appropriate skills, and performance of age-appropriate activities. The limitations may be the result of loss of function or failure in a single organ or body system, or a lesser degree of functional loss in two or more organs/body systems that, in combination with significant constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss, results in listing-level limitations. We use the term ''severe'' in these listings to describe medical severity; the term does not have the same meaning as it does when we use it in connection with a finding at the second step of the sequential evaluation processes in §§404.1520, 416.920, and 416.924.

C. Allergies, growth impairments and Kawasaki disease.

1. Allergic disorders (e.g., asthma or atopic dermatitis) are discussed and evaluated under the appropriate listing of the affected body system.

2. If growth is affected by the disorder or its treatment by immunosuppressive drugs, 100.00 may apply.

3. Kawasaki disease, also known as mucocutaneous lymph node syndrome, is characterized by multisystem manifestations, but significant functional impairment is usually due to disease of the coronary arteries, which should be evaluated under 104.00.

D. Human immunodeficiency virus (HIV) infection.

1. HIV infection is caused by a specific retrovirus and may be characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions, as described in 114.08. Any child with HIV infection, including one with a diagnosis of acquired immunodeficiency syndrome (AIDS), may be found disabled under this listing if his or her impairment meets any of the criteria in 114.08 or is of equivalent severity to an impairment in 114.08.

2. Definitions. In 114.08, the terms ''resistant to treatment,'' ''recurrent,'' and ''disseminated'' have the same general meaning as used by the medical community. The precise meaning of any of these terms will depend upon the specific disease or condition in question, the body system affected, the usual course of the disorder and its treatment, and the other circumstances of the case.

''Resistant to treatment'' means that a condition did not respond adequately to an appropriate course of treatment. Whether a response is adequate, or a course of treatment appropriate, will depend on the facts of the particular case.

''Recurrent'' means that a condition that responded adequately to an appropriate course of treatment has returned after a period of remission or regression. The extent of response (or remission) and the time periods involved will depend on the facts of the particular case.

''Disseminated'' means that a condition is spread widely over a considerable area or body system(s). The type and extent of the spread will depend on the specific disease.

3. Documentation of HIV infection in children. The medical evidence must include documentation of HIV infection. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of HIV infection in children by definitive diagnosis. A definitive diagnosis of HIV infection in children is documented by one or more of the following laboratory tests:

i. For a child 24 months of age or older, a serum specimen that contains HIV antibodies. HIV antibodies are usually detected by a screening test. The most commonly used screening test is the ELISA. Although this test is highly sensitive, it may yield false positive results. Therefore, positive results from an ELISA must be confirmed by a more definitive test (e.g., Western blot, immunofluorescence assay). (See paragraph b, below, for information about HIV antibody testing in children younger than 24 months of age).

ii. A specimen that contains HIV antigen (e.g., serum specimen, lymphocyte culture, or cerebrospinal fluid (CSF) specimen).

iii. An immunoglobulin A (IgA) serological assay specific for HIV.

iv. Other test(s) that are highly specific for detection of HIV in children (e.g., polymerase chain reaction (PCR)), or that are acceptable methods of detection consistent with the prevailing state of medical knowledge.

When laboratory testing for HIV infection has been performed, every reasonable effort must be made to obtain reports of the results of that testing.

b. Other acceptable documentation of HIV infection in children.

As noted in paragraph a, above, HIV infection is not documented in children under 24 months of age by a serum specimen containing HIV antibodies. This is because women with HIV infection often transfer HIV antibodies to their newborns. The mother's antibodies can persist in the infant for up to 24 months, even if the infant is not HIV-infected. Only 20 to 30 percent of such infants are actually infected. Therefore, the presence of serum HIV antibodies alone does not establish the presence of HIV infection in a child under 24 months of age. However, the presence of HIV antibodies accompanied by evidence of significantly depressed T-helper lymphocytes (CD4), an abnormal CD4/CD8 ratio, or abnormal immunoglobulin G (IgG) may be used to document HIV infection in a child under 24 months of age, even though such testing is not a basis for a definitive diagnosis.

For children from birth to the attainment of 24 months of age who have tested positive for HIV antibodies (see D3a above), HIV infection may be documented by one or more of the following:

i. For an infant 12 months of age or less, a CD4 (T4) count of 1500/mm^3 or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

ii. For an infant from 12 to 24 months of age, a CD4 (T4) count of 750/mm^3 or less, or a CD4 count less than or equal to 20 percent of total lymphocytes.

iii. An abnormal CD4/CD8 ratio.

iv. An IgG significantly greater than or less than the normal range for age.

HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, or the other laboratory evidence discussed above, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If such laboratory evidence is not available, HIV infection may be documented by the medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. For example, a diagnosis of HIV infection in children will be accepted without definitive laboratory evidence if the child has an opportunistic disease (e.g., Pneumocystis carinii pneumonia (PCP)) predictive of a defect in cell-mediated immunity, and there is no other known cause of diminished resistance to that disease (e.g., long-term steroid treatment, lymphoma). In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

4. Documentation of the manifestations of HIV infection in children. The medical evidence must also include documentation of the manifestations of HIV infection in children. Documentation may be by laboratory evidence or by other generally acceptable methods consistent with the prevailing state of medical knowledge and clinical practice.

a. Documentation of the manifestations of HIV infection in children by definitive diagnosis.

The definitive method of diagnosing opportunistic diseases or conditions that are manifestations of HIV infection in children is by culture, serological test, or microscopic examination of biopsied tissue or other material (e.g., bronchial washings). Therefore, every reasonable effort must be made to obtain specific laboratory evidence of an opportunistic disease or other condition whenever this information is available. If a histological or other test has been performed, the evidence should include a copy of the appropriate report. If the report is not obtainable, the summary of hospitalization or a report from the treating source should include details of the findings and results of the diagnostic studies (including radiographic studies) or microscopic examination of the appropriate tissues or body fluids.

Although a reduced CD4 lymphocyte count in a child may show that there is an increased susceptibility to opportunistic infections and diseases, that alone does not document the presence, severity, or functional effects of a manifestation of HIV infection in a child.

b. Other acceptable documentation of the manifestations of HIV infection in children.

Manifestations of HIV infection in children may also be documented without the definitive laboratory evidence described in paragraph a, provided that such documentation is consistent with the prevailing state of medical knowledge and clinical practice and is consistent with the other evidence. If no definitive laboratory evidence is available, manifestations of HIV infection may be documented by medical history, clinical and laboratory findings, and diagnosis(es) indicated in the medical evidence. In such cases, every reasonable effort must be made to obtain full details of the history, medical findings, and results of testing.

Documentation of cytomegalovirus (CMV) disease (114.08D) presents special problems because diagnosis requires identification of viral inclusion bodies or a positive culture from the affected organ, and the absence of any other infectious agent. A positive serology test identifies infection with the virus, but does not confirm a disease process. With the exception of chorioretinitis (which may be diagnosed by an ophthalmologist), documentation of CMV disease requires confirmation by biopsy or other generally acceptable

methods consistent with the prevailing state of medical knowledge and clinical practice.

5. HIV infection in children. The clinical manifestation and course of disease in children who become infected with HIV perinatally or in the first 6 years of life may differ from that in older children and adults. In addition, survival times are shorter for children infected in the first year of life compared to those who become infected as older children or as adults. Infants may present with failure to thrive or pneumocystis carinii pneumonia (PCP); young children may present with recurrent infections, neurological problems, or developmental abnormalities. Older children may also exhibit neurological abnormalities, such as HIV encephalopathy, or failure to thrive.

The methods of identifying and evaluating neurological abnormalities may vary depending on a child's age. For example, in an infant, impaired brain growth can be documented by a decrease in the growth rate of the head. In older children, impaired brain growth can be documented by brain atrophy on a CAT scan. Neurological abnormalities can also be observed in a younger child in the loss of previously acquired, or marked delays in achieving, developmental milestones. In an older child, this type of neurological abnormality would generally be demonstrated by the loss of previously acquired intellectual abilities. Although loss of previously acquired intellectual abilities can be documented by a decrease in intelligence quotient (IQ) scores or demonstrated if a child forgets information he or she previously learned, it can also be shown if the child is unable to learn new information. This could include the sudden acquisition of a new learning disability.

Children with HIV infection may contract any of a broad range of bacterial infections. Certain major infections caused by pyogenic bacteria, e.g., some pneumonias, can be severely limiting, especially in pre-adolescent children. These major bacterial infections should be evaluated under 114.08A5, which requires two or more such infections within a 2-year period. Although 114.08A5 applies only to children less than 13 years of age, an older child may be found to have an impairment of equivalent severity if the circumstances of the case warrant (e.g., delayed puberty).

Otherwise, bacterial infections are evaluated under 114.08A6. The criteria of the listing are met if one or more bacterial infection(s) occurs and requires hospitalization or intravenous antibiotic treatment 3 or more times in 1 year. Pelvic inflammatory disease in older female children should be evaluated under multiple or recurrent bacterial infections (114.08A6).

6. Evaluation of HIV infection in children. The criteria in 114.08 do not describe the full spectrum of diseases or conditions manifested by children with HIV infection. As in any case, consideration must be given to whether a child's impairment(s) meets, medically equals, or functionally equals the severity of any other listing in appendix 1 of subpart P; e.g., a neoplastic disorder listed in 113.00ff. (See §§404.1526, 416.926, and 416.926a.) Although 114.08 includes cross-references to other listings for the more common manifestations of HIV infection, additional listings may also apply.

In addition, the impact of all impairments, whether or not related to the HIV infection, must be considered. Children with HIV infection may manifest signs and symptoms of a mental impairment (e.g., anxiety, depression), or of another physical impairment. Medical evidence should include documentation of all physical and mental impairments and the impairment(s) should be evaluated not only under the relevant listing(s) in 114.08, but under any other appropriate listing(s).

It is also important to remember that children with HIV infection, like all others, are evaluated under the full sequential evaluation process described in §416.924. If a child with HIV infection is working and engaging in substantial gainful activity (SGA), or does not have a severe impairment, the case will be decided at the first or second step of the sequential evaluation process, and does not require evaluation under these listings. For a child with HIV infection who is not engaging in SGA and has a severe impairment, but whose impairment(s) does not meet the criteria of a listing, consideration will be given to whether the child's impairment or combination of impairments is either medically or functionally equivalent in severity to any listed impairment.

7. Effect of treatment. Medical treatment must be considered in terms of its effectiveness in ameliorating the signs, symptoms, and laboratory abnormalities of the specific disorder, or of the HIV infection itself (e.g. antiretroviral agents) and in terms of any side effects of treatment that may further impair the child.

Response to treatment and adverse or beneficial consequences of treatment may vary widely. For example, a child with HIV infection who develops otitis media may respond to the same antibiotic regimen used in treating children without HIV infection, but another child with HIV infection may not respond to the same regimen. Therefore, each case must be considered on an individual basis, along with the effects of treatment on the child's ability to function.

A specific description of the drugs or treatment given (including surgery), dosage, frequency of administration, and a description of the complications or response to treatment should be obtained. The effects of treatment may be temporary or long-term. As such, the decision regarding the impact of

treatment should be based on a sufficient period of treatment to permit proper consideration.

8. Functional criteria. Paragraph O of 114.08 establishes standards for evaluating manifestations of HIV infection that do not meet the requirements listed in 114.08A-N. Paragraph O is applicable for manifestations that are not listed in 114.08A-N, as well as those listed in 114.08A-N that do not meet the criteria of any of the rules in 114.08A-N.

For children with HIV infection evaluated under 114.08O, listing-level severity will be assessed in terms of the functional limitations imposed by the impairment. The full impact of signs, symptoms, and laboratory findings on the child's ability to function must be considered. Important factors to be considered in evaluating the functioning of children with HIV infection include, but are not limited to: symptoms, such as fatigue and pain; characteristics of the illness, such as the frequency and duration of manifestations or periods of exacerbation and remission in the disease course; and the functional impact of treatment for the disease, including the side effects of medication.

To meet the criteria in 114.08O, a child with HIV infection must demonstrate a level of restriction in either one or two (depending on the child's age) of the general areas of functioning applicable to the child's age group. (See 112.00C for additional discussion of these areas of functioning).

114.01 Category of Impairments, Immune System

114.02 Systemic lupus erythematosus. Documented as described in 14.00B1 and 114.00B, with:

A. One of the following:

1. Growth impairment, as described under the criteria in 100.00ff; or

2. Musculoskeletal involvement, as described under the criteria in 101.00ff; or

3. Muscle involvement, as described under the criteria in 14.05; or

4. Ocular involvement, as described under the criteria in 102.00ff; or

5. Respiratory involvement, as described under the criteria in 103.00ff; or

6. Cardiovascular involvement, as described under the criteria in 104.00ff or 14.04D; or

7. Digestive involvement, as described under the criteria in 105.00ff; or

8. Renal involvement, as described under the criteria in 106.00ff; or

9. Hematologic involvement, as described under the criteria in 107.00ff; or

10. Skin involvement, as described under the criteria in 8.00ff; or

11. Endocrine involvement, as described under the criteria in 109.00ff; or

12. Neurological involvement, as described under the criteria in 111.00ff; or

13. Mental involvement, as described under the criteria in 112.00ff.

or

B. Lesser involvement of two or more organs/body systems listed in paragraph A, with significant, documented, constitutional symptoms and signs of severe fatigue, fever, malaise, and weight loss. At least one of the organs/body systems must be involved to at least a moderate level of severity.

114.03 Systemic vasculitis. As described under the criteria in 14.03 or, if growth impairment, as described under the criteria in 100.00ff.

114.04 Systemic sclerosis and scleroderma. Documented as described in 14.00B3 and 114.00B, and:

A. As described under the criteria in 14.04 or, if growth impairment, as described under the criteria in 100.00ff.

or

B. Linear scleroderma, with one of the following:

1. Fixed valgus or varus deformities of both hands or both feet; or

2. Marked destruction or marked atrophy of an extremity; or

3. Facial disfigurement from hypoplasia of the mandible, maxilla, or zygoma resulting in an impairment as described under the criteria in 112.00ff; or

4. Seizure disorder, as described under the criteria in 111.00ff.

114.05 Polymyositis or dermatomyositis. Documented as described in 14.00B4 and 114.00B, and:

A. As described under the criteria in 14.05.

or

B. With one of the following:

1. Multiple joint contractures; or

2. Diffuse cutaneous calcification with formation of an exoskeleton; or

3. Systemic vasculitis as described under the criteria in 14.03.

114.06 Undifferentiated connective tissue disorder. As described under the criteria in 114.02 or 114.04.

114.07 Congenital immune deficiency disease.

A. Hypogammaglobulinemia or dysgammaglobulinemia, with:

1. Documented, recurrent severe infections occurring 3 or more times within a 5-month period; or

2. An associated disorder such as growth retardation, chronic lung disease, collagen disorder or tumor. Evaluate according to the appropriate body system listing.

or

B. Thymic dysplastic syndromes (such as Swiss, diGeorge).

114.08 Human immunodeficiency virus (HIV) infection. With documentation as described in 114.00D3 and one of the following:

A. Bacterial infections:

1. Mycobacterial infection (e.g., caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis) at a site other than the lungs,

skin, or cervical or hilar lymph nodes; or pulmonary tuberculosis resistant to treatment; or

2. Nocardiosis; or

3. Salmonella bacteremia, recurrent nontyphoid.

4. Syphilis or neurosyphilis—evaluate sequelae under the criteria for the affected body system (e.g., 102.00 Special Senses and Speech, 104.00 Cardiovascular System, 111.00 Neurological); or

5. In a child less than 13 years of age, multiple or recurrent pyogenic bacterial infection(s) of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring 2 or more times in 2 years; or

6. Other multiple or recurrent bacterial infection(s), including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year.

or

B. Fungal infections:

1. Aspergillosis; or

2. Candidiasis, at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs; or

3. Coccidioidomycosis, at a site other than the lungs or lymph nodes; or

4. Cryptococcosis, at a site other than the lungs (e.g., cryptococcal meningitis); or

5. Histoplasmosis, at a site other than the lungs or lymph nodes; or

6. Mucormycosis.

or

C. Protozoan or helminthic infections:

1. Cryptosporidiosis, isosporiasis, or microsporidiosis, with diarrhea lasting for 1 month or longer; or

2. Pneumocystis carinii pneumonia or extrapulmonary pneumocystis carinii infection; or

3. Strongyloidiasis, extra-intestinal; or

4. Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes.

or

D. Viral infections:

1. Cytomegalovirus disease (documented as described in 114.00D4b) at a site other than the liver, spleen, or lymph nodes; or

2. Herpes simplex virus causing:

a. Mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or

b. Infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or

c. Disseminated infection; or

3. Herpes zoster, either disseminated or with multidermatomal eruptions that are resistant to treatment; or

4. Progressive multifocal leukoencephalopathy; or

5. Hepatitis, as described under the criteria of 105.05.

or

E. Malignant neoplasms:

1. Carcinoma of the cervix, invasive, FIGO stage II and beyond; or

2. Karposi's sarcoma with:

a. Extensive oral lesions; or

b. Involvement of the gastrointestinal tract, lungs, or other visceral organs; or

c. Involvement of the skin or mucous membranes as described under the criteria of 114.08F; or

3. Lymphoma (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other Non-Hodgkin's lymphoma, Hodgkin's disease); or

4. Squamous cell carcinoma of the anus.

or

F. Conditions of the skin or mucous membranes (other than described in B2, D2, or D3 above) with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease), or evaluate under the criteria in 8.00ff.

or

G. Hematologic abnormalities:

1. Anemia, as described under the criteria in 7.02; or

2. Granulocytopenia, as described under the criteria in 7.15; or

3. Thrombocytopenia, as described under the criteria of 107.06 or 7.06.

or

H. Neurological manifestations of HIV infection (e.g., HIV encephalopathy, peripheral neuropathy), as described under the criteria in 111.00ff, or resulting in one or more of the following:

1. Loss of previously acquired, or marked delay in achieving, developmental milestones or intellectual ability (including the sudden acquisition of a new learning disability); or

2. Impaired brain growth (acquired microcephaly or brain atrophy—see 114.00D5); or

3. Progressive motor dysfunction affecting gait and station or fine and gross motor skills.

or

I. Growth disturbance, with:

1. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall of 15 percentiles from established growth curve (on standard growth charts) that persists for 2 months or longer; or

2. An involuntary weight loss (or failure to gain weight at an appropriate rate for age) resulting in a fall to below the third percentile from established growth curve (on standard growth charts) that persists for 2 months or longer; or

3. Involuntary weight loss greater than 10 percent of baseline that persists for 2 months or longer; or

4. Growth impairment as described under the criteria in 100.00ff.

or

J. Diarrhea, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding.

or

K. Cardiomyopathy, as described under the criteria in 104.00ff or 11.04.

or

L. Lymphoid interstitial pneumonia/pulmonary lymphoid hyperplasia (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment.

or

M. Nephropathy, as described under the criteria in 106.00.

or

N. One or more of the following infections (other than described in A–M, above), resistant to treatment or requiring hospitalization or intravenous treatment 3 or more times in 1 year (or evaluate sequelae under the criteria for the affected body system):

1. Sepsis;
2. Meningitis; or
3. Pneumonia; or
4. Septic arthritis; or
5. Endocarditis; or
6. Radiographically documented sinusitis.

or

O. Any other manifestation(s) of HIV infection (including any listed in 114.08A–N, but without the requisite findings, e.g., oral candidiasis not meeting the criteria in 114.08F, diarrhea not meeting the criteria in 114.08J, or any other manifestation(s), e.g., oral hairy leukoplakia, hepatomegaly), resulting in one of the following:

1. For children from birth to attainment of age 1, at least one of the criteria in paragraphs A–E of 112.12; or

2. For children age 1 to attainment of age 3, at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or

3. For children age 3 to attainment of age 18, at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

[50 FR 35066, Aug. 28, 1985]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting appendix 1 to subpart P of part 404, see the List of CFR Sections Affected in the Finding Aids section of this volume.

APPENDIX 2 TO SUBPART P OF PART 404—MEDICAL-VOCATIONAL GUIDELINES

Sec.
200.00 Introduction.
201.00 Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).
202.00 Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).
203.00 Maximum sustained work capability limited to medium work as a result of severe medically determinable impairment(s).
204.00 Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).

200.00 *Introduction.* (a) The following rules reflect the major functional and vocational patterns which are encountered in cases which cannot be evaluated on medical considerations alone, where an individual with a severe medically determinable physical or mental impairment(s) is not engaging in substantial gainful activity and the individual's impairment(s) prevents the performance of his or her vocationally relevant past work. They also reflect the analysis of the various vocational factors (i.e., age, education, and work experience) in combination with the individual's residual functional capacity (used to determine his or her maximum sustained work capability for sedentary, light, medium, heavy, or very heavy work) in evaluating the individual's ability to engage in substantial gainful activity in other than his or her vocationally relevant past work. Where the findings of fact made with respect to a particular individual's vocational factors and residual functional capacity coincide with all of the criteria of a particular rule, the rule directs a conclusion as to whether the individual is or is not disabled. However, each of these findings of fact is subject to rebuttal and the individual may present evidence to refute such findings. Where any one of the findings of fact does not coincide with the corresponding criterion of a rule, the rule does not apply in that particular case and, accordingly, does not direct a conclusion of disabled or not disabled. In any instance where a rule does not apply, full consideration must be given to all of the relevant facts of the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations.

(b) The existence of jobs in the national economy is reflected in the ''Decisions''

shown in the rules; i.e., in promulgating the rules, administrative notice has been taken of the numbers of unskilled jobs that exist throughout the national economy at the various functional levels (sedentary, light, medium, heavy, and very heavy) as supported by the ''Dictionary of Occupational Titles'' and the ''Occupational Outlook Handbook,'' published by the Department of Labor; the ''County Business Patterns'' and ''Census Surveys'' published by the Bureau of the Census; and occupational surveys of light and sedentary jobs prepared for the Social Security Administration by various State employment agencies. Thus, when all factors coincide with the criteria of a rule, the existence of such jobs is established. However, the existence of such jobs for individuals whose remaining functional capacity or other factors do not coincide with the criteria of a rule must be further considered in terms of what kinds of jobs or types of work may be either additionally indicated or precluded.

(c) In the application of the rules, the individual's residual functional capacity (i.e., the maximum degree to which the individual retains the capacity for sustained performance of the physical-mental requirements of jobs), age, education, and work experience must first be determined. When assessing the person's residual functional capacity, we consider his or her symptoms (such as pain), signs, and laboratory findings together with other evidence we obtain.

(d) The correct disability decision (i.e., on the issue of ability to engage in substantial gainful activity) is found by then locating the individual's specific vocational profile. If an individual's specific profile is not listed within this appendix 2, a conclusion of disabled or not disabled is not directed. Thus, for example, an individual's ability to engage in substantial gainful work where his or her residual functional capacity falls between the ranges of work indicated in the rules (e.g., the individual who can perform more than light but less than medium work), is decided on the basis of the principles and definitions in the regulations, giving consideration to the rules for specific case situations in this appendix 2. These rules represent various combinations of exertional capabilities, age, education and work experience and also provide an overall structure for evaluation of those cases in which the judgments as to each factor do not coincide with those of any specific rule. Thus, when the necessary judgments have been made as to each factor and it is found that no specific rule applies, the rules still provide guidance for decisionmaking, such as in cases involving combinations of impairments. For example, if strength limitations resulting from an individual's impairment(s) considered with the judgments made as to the individual's age, education and work experience correspond to (or closely approximate) the factors of a particular rule, the adjudicator then has a frame of reference for considering the jobs or types of work precluded by other, nonexertional impairments in terms of numbers of jobs remaining for a particular individual.

(e) Since the rules are predicated on an individual's having an impairment which manifests itself by limitations in meeting the strength requirements of jobs, they may not be fully applicable where the nature of an individual's impairment does not result in such limitations, e.g., certain mental, sensory, or skin impairments. In addition, some impairments may result solely in postural and manipulative limitations or environmental restrictions. Environmental restrictions are those restrictions which result in inability to tolerate some physical feature(s) of work settings that occur in certain industries or types of work, e.g., an inability to tolerate dust or fumes.

(1) In the evaluation of disability where the individual has solely a nonexertional type of impairment, determination as to whether disability exists shall be based on the principles in the appropriate sections of the regulations, giving consideration to the rules for specific case situations in this appendix 2. The rules do not direct factual conclusions of disabled or not disabled for individuals with solely nonexertional types of impairments.

(2) However, where an individual has an impairment or combination of impairments resulting in both strength limitations and nonexertional limitations, the rules in this subpart are considered in determining first whether a finding of disabled may be possible based on the strength limitations alone and, if not, the rule(s) reflecting the individual's maximum residual strength capabilities, age, education, and work experience provide a framework for consideration of how much the individual's work capability is further diminished in terms of any types of jobs that would be contraindicated by the nonexertional limitations. Also, in these combinations of nonexertional and exertional limitations which cannot be wholly determined under the rules in this appendix 2, full consideration must be given to all of the relevant facts in the case in accordance with the definitions and discussions of each factor in the appropriate sections of the regulations, which will provide insight into the adjudicative weight to be accorded each factor.

201.00 *Maximum sustained work capability limited to sedentary work as a result of severe medically determinable impairment(s).* (a) Most sedentary occupations fall within the skilled, semi-skilled, professional, administrative, technical, clerical, and benchwork classifications. Approximately 200 separate unskilled sedentary occupations can be identified, each representing numerous jobs in

the national economy. Approximately 85 percent of these jobs are in the machine trades and benchwork occupational categories. These jobs (unskilled sedentary occupations) may be performed after a short demonstration or within 30 days.

(b) These unskilled sedentary occupations are standard within the industries in which they exist. While sedentary work represents a significantly restricted range of work, this range in itself is not so prohibitively restricted as to negate work capability for substantial gainful activity.

(c) Vocational adjustment to sedentary work may be expected where the individual has special skills or experience relevant to sedentary work or where age and basic educational competences provide sufficient occupational mobility to adapt to the major segment of unskilled sedentary work. Inability to engage in substantial gainful activity would be indicated where an individual who is restricted to sedentary work because of a severe medically determinable impairment lacks special skills or experience relevant to sedentary work, lacks educational qualifications relevant to most sedentary work (e.g., has a limited education or less) and the individual's age, though not necessarily advanced, is a factor which significantly limits vocational adaptability.

(d) The adversity of functional restrictions to sedentary work at advanced age (55 and over) for individuals with no relevant past work or who can no longer perform vocationally relevant past work and have no transferable skills, warrants a finding of disabled in the the absence of the rare situation where the individual has recently completed education which provides a basis for direct entry into skilled sedentary work. Advanced age and a history of unskilled work or no work experience would ordinarily offset any vocational advantages that might accrue by reason of any remote past education, whether it is more or less than limited education.

(e) The presence of acquired skills that are readily transferable to a significant range of skilled work within an individual's residual functional capacity would ordinarily warrant a finding of ability to engage in substantial gainful activity regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) In order to find transferability of skills to skilled sedentary work for individuals who are of advanced age (55 and over), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) Individuals approaching advanced age (age 50–54) may be significantly limited in vocational adaptability if they are restricted to sedentary work. When such individuals have no past work experience or can no longer perform vocationally relevant past work and have no transferable skills, a finding of disabled ordinarily obtains. However, recently completed education which provides for direct entry into sedentary work will preclude such a finding. For this age group, even a high school education or more (ordinarily completed in the remote past) would have little impact for effecting a vocational adjustment unless relevant work experience reflects use of such education.

(h) The term *younger individual* is used to denote an individual age 18 through 49. For those within this group who are age 45–49, age is a less positive factor than for those who are age 18–44. Accordingly, for such individuals; (1) who are restricted to sedentary work, (2) who are unskilled or have no transferable skills, (3) who have no relevant past work or who can no longer perform vocationally relevant past work, and (4) who are either illiterate or unable to communicate in the English language, a finding of disabled is warranted. On the other hand, age is a more positive factor for those who are under age 45 and is usually not a significant factor in limiting such an individual's ability to make a vocational adjustment, even an adjustment to unskilled sedentary work, and even where the individual is illiterate or unable to communicate in English. However, a finding of disabled is not precluded for those individuals under age 45 who do not meet all of the criteria of a specific rule and who do not have the ability to perform a full range of sedentary work. The following examples are illustrative: Example 1: An individual under age 45 with a high school education can no longer do past work and is restricted to unskilled sedentary jobs because of a severe medically determinable cardiovascular impairment (which does not meet or equal the listings in appendix 1). A permanent injury of the right hand limits the individual to sedentary jobs which do not require bilateral manual dexterity. None of the rules in appendix 2 are applicable to this particular set of facts, because this individual cannot perform the full range of work defined as sedentary. Since the inability to perform jobs requiring bilateral manual dexterity significantly compromises the only range of work for which the individual is otherwise qualified (i.e., sedentary), a finding of disabled would be appropriate. Example 2: An illiterate 41 year old individual with mild mental retardation (IQ of 78) is restricted to unskilled sedentary work and cannot perform vocationally relevant past work, which had consisted of unskilled agricultural field work; his or her particular characteristics do

not specifically meet any of the rules in appendix 2, because this individual cannot perform the full range of work defined as sedentary. In light of the adverse factors which further narrow the range of sedentary work for which this individual is qualified, a finding of disabled is appropriate.

(i) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. Thus, the functional capability for a full range of sedentary work represents sufficient numbers of jobs to indicate substantial vocational scope for those individuals age 18–44 even if they are illiterate or unable to communicate in English.

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
201.01	Advanced age	Limited or less	Unskilled or none	Disabled
201.02	do	do	Skilled or semiskilled—skills not transferable [1].	Do.
201.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled
201.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled
201.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled
201.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Disabled
201.07	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled
201.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable [1].	Do.
201.09	Closely approaching advanced age.	Limited or less	Unskilled or none	Disabled
201.10	do	do	Skilled or semiskilled—skills not transferable.	Do.
201.11	do	do	Skilled or semiskilled—skills transferable.	Not disabled
201.12	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Unskilled or none	Disabled
201.13	do	High school graduate or more—provides for direct entry into skilled work [3].	do	Not disabled
201.14	do	High school graduate or more—does not provide for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Disabled
201.15	do	do	Skilled or semiskilled—skills transferable.	Not disabled
201.16	do	High school graduate or more—provides for direct entry into skilled work [3].	Skilled or semiskilled—skills not transferable.	Do.
201.17	Younger individual age 45–49.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled
201.18	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled
201.19	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
201.20	do	do	Skilled or semiskilled—skills transferable.	Do.
201.21	do	High school graduate or more	Skilled or semiskilled—skills not transferable.	Do.
201.22	do	do	Skilled or semiskilled—skills transferable.	Do.
201.23	Younger individual age 18–44.	Illiterate or unable to communicate in English.	Unskilled or none	Do.[4]
201.24	do	Limited or less—at least literate and able to communicate in English.	do	Do.[4]

TABLE NO. 1—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO SEDENTARY WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
201.25 ...	.....do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.[4]
201.26 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]
201.27 ...	.....do	High school graduate or more	Unskilled or none	Do.[4]
201.28 ...	.....do	.....do	Skilled or semiskilled—skills not transferable.	Do.[4]
201.29 ...	.....do	.....do	Skilled or semiskilled—skills transferable.	Do.[4]

[1] See 201.00(f).
[2] See 201.00(d).
[3] See 201.00(g).
[4] See 201.00(h).

202.00 *Maximum sustained work capability limited to light work as a result of severe medically determinable impairment(s).* (a) The functional capacity to perform a full range of light work includes the functional capacity to perform sedentary as well as light work. Approximately 1,600 separate sedentary and light unskilled occupations can be identified in eight broad occupational categories, each occupation representing numerous jobs in the national economy. These jobs can be performed after a short demonstration or within 30 days, and do not require special skills or experience.

(b) The functional capacity to perform a wide or full range of light work represents substantial work capability compatible with making a work adjustment to substantial numbers of unskilled jobs and, thus, generally provides sufficient occupational mobility even for severely impaired individuals who are not of advanced age and have sufficient educational competences for unskilled work.

(c) However, for individuals of advanced age who can no longer perform vocationally relevant past work and who have a history of unskilled work experience, or who have only skills that are not readily transferable to a significant range of semi-skilled or skilled work that is within the individual's functional capacity, or who have no work experience, the limitations in vocational adaptability represented by functional restriction to light work warrant a finding of disabled. Ordinarily, even a high school education or more which was completed in the remote past will have little positive impact on effecting a vocational adjustment unless relevant work experience reflects use of such education.

(d) Where the same factors in paragraph (c) of this section regarding education and work experience are present, but where age, though not advanced, is a factor which significantly limits vocational adaptability (i.e., closely approaching advanced age, 50–54) and an individual's vocational scope is further significantly limited by illiteracy or inability to communicate in English, a finding of disabled is warranted.

(e) The presence of acquired skills that are readily transferable to a significant range of semi-skilled or skilled work within an individual's residual functional capacity would ordinarily warrant a finding of not disabled regardless of the adversity of age, or whether the individual's formal education is commensurate with his or her demonstrated skill level. The acquisition of work skills demonstrates the ability to perform work at the level of complexity demonstrated by the skill level attained regardless of the individual's formal educational attainments.

(f) For a finding of transferability of skills to light work for individuals of advanced age who are closely approaching retirement age (age 60–64), there must be very little, if any, vocational adjustment required in terms of tools, work processes, work settings, or the industry.

(g) While illiteracy or the inability to communicate in English may significantly limit an individual's vocational scope, the primary work functions in the bulk of unskilled work relate to working with things (rather than with data or people) and in these work functions at the unskilled level, literacy or ability to communicate in English has the least significance. Similarly, the lack of relevant work experience would have little significance since the bulk of unskilled jobs require no qualifying work experience. The capability for light work, which includes the ability to do sedentary work, represents the capability for substantial numbers of such jobs. This, in turn, represents substantial vocational scope for younger individuals (age 18–49) even if illiterate or unable to communicate in English.

TABLE NO. 2—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO LIGHT WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
202.01	Advanced age	Limited or less	Unskilled or none	Disabled.
202.02	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.03	do	do	Skilled or semiskilled—skills transferable [1].	Not disabled.
202.04	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Unskilled or none	Disabled.
202.05	do	High school graduate or more—provides for direct entry into skilled work [2].	do	Not disabled.
202.06	do	High school graduate or more—does not provide for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Disabled.
202.07	do	do	Skilled or semiskilled—skills transferable [2].	Not disabled.
202.08	do	High school graduate or more—provides for direct entry into skilled work [2].	Skilled or semiskilled—skills not transferable.	Do.
202.09	Closely approaching advanced age.	Illiterate or unable to communicate in English.	Unskilled or none	Disabled.
202.10	do	Limited or less—at least literate and able to communicate in English.	do	Not disabled.
202.11	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.12	do	do	Skilled or semiskilled—skills transferable.	Do.
202.13	do	High school graduate or more	Unskilled or none	Do.
202.14	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.15	do	do	Skilled or semiskilled—skills transferable.	Do.
202.16	Younger individual	Illiterate or unable to communicate in English.	Unskilled or none	Do.
202.17	do	Limited or less—at least literate and able to communicate in English.	do	Do.
202.18	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
202.19	do	do	Skilled or semiskilled—skills transferable.	Do.
202.20	do	High school graduate or more	Unskilled or none	Do.
202.21	do	do	Skilled or semiskilled—skills not transferable.	Do.
202.22	do	do	Skilled or semiskilled—skills transferable.	Do.

[1] See 202.00(f).
[2] See 202.00(c).

203.00 *Maximum sustained work capability limited to medium work as a result of severe medically determinable impair- ment(s).* (a) The functional capacity to perform medium work includes the functional capacity to perform sedentary, light, and medium work. Approximately 2,500 separate sedentary, light, and medium occupations can be identified, each occupation representing numerous jobs in the national economy which do not require skills or previous experience and which can be performed after a short demonstration or within 30 days.

(b) The functional capacity to perform medium work represents such substantial work capability at even the unskilled level that a finding of disabled is ordinarily not warranted in cases where a severely impaired individual retains the functional capacity to perform medium work. Even the adversity of advanced age (55 or over) and a work history of unskilled work may be offset by the substantial work capability represented by the functional capacity to perform medium work. However, an individual with a marginal education and long work experience

(i.e., 35 years or more) limited to the performance of arduous unskilled labor, who is not working and is no longer able to perform this labor because of a severe impairment(s), may still be found disabled even though the individual is able to do medium work.

(c) However, the absence of any relevant work experience becomes a more significant adversity for individuals of advanced age (55 and over). Accordingly, this factor, in combination with a limited education or less, militates against making a vocational adjustment to even this substantial range of work and a finding of disabled is appropriate. Further, for individuals closely approaching retirement age (60–64) with a work history of unskilled work and with marginal education or less, a finding of disabled is appropriate.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)

Rule	Age	Education	Previous work experience	Decision
203.01	Closely approaching retirement age.	Marginal or none	Unskilled or none	Disabled.
203.02	do	Limited or less	None	Do.
203.03	do	Limited	Unskilled	Not disabled.
203.04	do	Limited or less	Skilled or semiskilled—skills not transferable.	Do.
203.05	do	do	Skilled or semiskilled—skills transferable.	Do.
203.06	do	High school graduate or more	Unskilled or none	Do.
203.07	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.08	do	do	Skilled or semiskilled—skills transferable.	Do.
203.09	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.10	Advanced age	Limited or less	None	Disabled.
203.11	do	do	Unskilled	Not disabled.
203.12	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.13	do	do	Skilled or semiskilled—skills transferable.	Do.
203.14	do	High school graduate or more	Unskilled or none	Do.
203.15	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.16	do	do	Skilled or semiskilled—skills transferable.	Do.
203.17	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.18	Closely approaching advanced age.	Limited or less	Unskilled or none	Do.
203.19	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.20	do	do	Skilled or semiskilled—skills transferable.	Do.
203.21	do	High school graduate or more	Unskilled or none	Do.
203.22	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.23	do	do	Skilled or semiskilled—skills transferable.	Do.
203.24	do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.25	Younger individual	Limited or less	Unskilled or none	Do.
203.26	do	do	Skilled or semiskilled—skills not transferable.	Do.
203.27	do	do	Skilled or semiskilled—skills transferable.	Do.
203.28	do	High school graduate or more	Unskilled or none	Do.
203.29	do	High school graduate or more—does not provide for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.
203.30	do	do	Skilled or semiskilled—skills transferable.	Do.

TABLE NO. 3—RESIDUAL FUNCTIONAL CAPACITY: MAXIMUM SUSTAINED WORK CAPABILITY LIMITED TO MEDIUM WORK AS A RESULT OF SEVERE MEDICALLY DETERMINABLE IMPAIRMENT(S)—Continued

Rule	Age	Education	Previous work experience	Decision
203.31	.....do	High school graduate or more—provides for direct entry into skilled work.	Skilled or semiskilled—skills not transferable.	Do.

204.00 *Maximum sustained work capability limited to heavy work (or very heavy work) as a result of severe medically determinable impairment(s).* The residual functional capacity to perform heavy work or very heavy work includes the functional capability for work at the lesser functional levels as well, and represents substantial work capability for jobs in the national economy at all skill and physical demand levels. Individuals who retain the functional capacity to perform heavy work (or very heavy work) ordinarily will not have a severe impairment or will be able to do their past work—either of which would have already provided a basis for a decision of ''not disabled''. Environmental restrictions ordinarily would not significantly affect the range of work existing in the national economy for individuals with the physical capability for heavy work (or very heavy work). Thus an impairment which does not preclude heavy work (or very heavy work) would not ordinarily be the primary reason for unemployment, and generally is sufficient for a finding of not disabled, even though age, education, and skill level of prior work experience may be considered adverse.

[45 FR 55584, Aug. 20, 1980, as amended at 56 FR 57944, Nov. 14, 1991]

Subpart Q—Determinations of Disability

AUTHORITY: Secs. 205(a), 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 421, and 902(a)(5)).

SOURCE: 46 FR 29204, May 29, 1981, unless otherwise noted.

GENERAL PROVISIONS

§404.1601 Purpose and scope.

This subpart describes the standards of performance and administrative requirements and procedures for States making determinations of disability for the Commissioner under title II of the Act. It also establishes the Commissioner's responsibilities in carrying out the disability determination function.

(a) Sections 404.1601 through 404.1603 describe the purpose of the regulations and the meaning of terms frequently used in the regulations. They also briefly set forth the responsibilities of the Commissioner and the States covered in detail in other sections.

(b) Sections 404.1610 through 404.1618 describe the Commissioner's and the State's responsibilities in performing the disability determination function.

(c) Sections 404.1620 through 404.1633 describe the administrative responsibilities and requirements of the States. The corresponding role of the Commissioner is also set out.

(d) Sections 404.1640 through 404.1650 describe the performance accuracy and processing time standards for measuring State agency performance.

(e) Sections 404.1660 through 404.1661 describe when and what kind of assistance the Commissioner will provide State agencies to help them improve performance.

(f) Sections 404.1670 through 404.1675 describe the level of performance below which the Commissioner 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 Commissioner will take.

(g) Sections 404.1680 through 404.1683 describe the rules for resolving disputes concerning fiscal issues and providing hearings when we propose to find that a State is in substantial failure.

(h) Sections 404.1690 through 404.1694 describe when and what action the Commissioner will take and what action the State will be expected to take if the Commissioner assumes the disability determination function from a State agency.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38451, July 18, 1997

§ 404.1602 Definitions.

For purposes of this subpart:

Act means the Social Security Act, as amended.

Class or classes of cases means the categories into which disability claims are divided according to their characteristics.

Commissioner means the Commissioner of Social Security or his or her authorized designee.

Determination of disability or *disability determination* means one or more of the following decisions:

(a) Whether or not a person is under a disability;

(b) The date a person's disability began; or

(c) The date a person's disability ended.

Disability means *disability* or *blindness* as defined in sections 216(i) and 223 of the Act or as defined in title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Disability determination function means making determinations as to disability and carrying out related administrative and other responsibilities.

Disability program means, as appropriate, the Federal programs for providing disability insurance benefits under title II of the Act and disability benefits under title IV of the Federal Mine Safety and Health Act of 1977, as amended.

Initial means the first level of disability adjudication.

Other written guidelines means written issuances such as Social Security Rulings and memoranda by the Commissioner of Social Security, the Deputy Commissioner for Programs and Policy, or the Associate Commissioner for Disability and the procedures, guides, and operating instructions in the Disability Insurance sections of the Program Operations Manual System, that are instructive, interpretive, clarifying, and/or administrative and not designated as advisory or discretionary. The purpose of including the foregoing material in the definition is to assure uniform national application of program standards and service delivery to the public.

Regulations means regulations in this subpart issued under sections 205(a), 221 and 1102 of the Act, unless otherwise indicated.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, or Guam. It includes the State agency.

State agency means that agency of a State which has been designated by the State to carry out the disability determination function.

We, us, and *our* refers to the Social Security Administration (SSA).

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

§ 404.1603 Basic responsibilities for us and the State.

(a) *General.* We will work with the State to provide and maintain an effective system for processing claims of those who apply for and who are receiving benefits under the disability program. We will provide program standards, leadership, and oversight. We do not intend to become involved in the State's ongoing management of the program except as is necessary and in accordance with these regulations. The State will comply with our regulations and other written guidelines.

(b) *Our responsibilities.* We will:

(1) Periodically review the regulations and other written guidelines to determine whether they insure effective and uniform administration of the disability program. To the extent feasible, we will consult with and take into consideration the experience of the States in issuing regulations and guidelines necessary to insure effective and uniform administration of the disability program;

(2) Provide training materials or in some instances conduct or specify training, see § 404.1622;

(3) Provide funds to the State agency for the necessary cost of performing the disability determination function, see § 404.1626;

(4) Monitor and evaluate the performance of the State agency under the established standards, see §§ 404.1644 and 404.1645; and

(5) Maintain liaison with the medical profession nationally and with national

organizations and agencies whose interests or activities may affect the disability program.

(c) *Responsibilities of the State.* The State will:

(1) Provide management needed to insure that the State agency carries out the disability determination function so that disability determinations are made accurately and promptly;

(2) Provide an organizational structure, adequate facilities, qualified personnel, medical consultant services, and a quality assurance function (§§404.1620 through 404.1624);

(3) Furnish reports and records relating to the administration of the disability program (§404.1625);

(4) Submit budgets (§404.1626);

(5) Cooperate with audits (§404.1627);

(6) Insure that all applicants for and recipients of disability benefits are treated equally and courteously;

(7) Be responsible for property used for disability program purposes (§404.1628);

(8) Take part in the research and demonstration projects (§404.1629);

(9) Coordinate with other agencies (§404.1630);

(10) Safeguard the records created by the State in performing the disability determination function (§404.1631);

(11) Comply with other provisions of the Federal law and regulations that apply to the State in performing the disability determination function;

(12) Comply with other written guidelines (§404.1633);

(13) Maintain liaison with the medical profession and organizations that may facilitate performing the disability determination function; and

(14) Assist us in other ways that we determine may promote the objectives of effective and uniform administration.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

§404.1610 How a State notifies us that it wishes to perform the disability determination function.

(a) *Deemed notice.* Any State that has in effect as of June 1, 1981, an agreement with us to make disability determinations will be deemed to have given us notice that it wishes to perform the disability determination function, in lieu of continuing the agreement in effect after June 1, 1981.

(b) *Written notice.* After June 1, 1981, a State not making disability determinations that wishes to perform the disability determination function under these regulations must notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State.

§404.1611 How we notify a State whether it may perform the disability determination function.

(a) If a State notifies us in writing that it wishes to perform the disability determination function, we will notify the State in writing whether or not it may perform the function. The State will begin performing the disability determination function beginning with the month we and the State agree upon.

(b) If we have previously found that a State agency has substantially failed to make disability determinations in accordance with the law or these regulations and other written guidelines or if the State has previously notified us in writing that it does not wish to make disability determinations, the notice will advise the State whether the State agency may again make the disability determinations and, if so, the date and the conditions under which the State may again make them.

§404.1613 Disability determinations the State makes.

(a) *General rule.* A State agency will make determinations of disability with respect to all persons in the State except those individuals whose cases are in a class specifically excluded by our written guidelines. A determination of disability made by the State is the determination of the Commissioner, except as described in §404.1503(d)(1).

(b) *New classes of cases.* Where any new class or classes of cases arise requiring determinations of disability, we will determine the conditions under which a State may choose not to make the disability determinations. We will

provide the State with the necessary funding to do the additional work.

(c) *Temporary transfer of classes of cases.* We will make disability determinations for classes of cases temporarily transferred to us by the State agency if the State agency asks us to do so and we agree. The State agency will make written arrangements with us which will specify the period of time and the class or classes of cases we will do.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§ 404.1614 Responsibilities for obtaining evidence to make disability determinations.

(a) The State agency will secure from the claimant, or other sources, any evidence it needs to make a disability determination.

(b) We will secure from the claimant or other special arrangement sources, any evidence we can obtain as adequately and more readily than the State agency. We will furnish the evidence to the State agency for use in making a disability determination.

(c) At our request, the State agency will obtain and furnish medical or other evidence and provide assistance as may be necessary for us to carry out our responsibilities—

(1) For making disability determinations in those classes of cases described in the written guidelines for which the State agency does not make the determination; or

(2) Under international agreements with respect to social security benefits payable under section 233 of the Act.

§ 404.1615 Making disability determinations.

(a) When making a disability determination, the State agency will apply subpart P, part 404, of our regulations.

(b) The State agency will make disability determinations based only on the medical and nonmedical evidence in its files.

(c) Disability determinations will be made by either:

(1) A State agency medical or psychological consultant and a State agency disability examiner;

(2) A State agency disability examiner alone when there is no medical evidence to be evaluated (i.e., no medical evidence exists or we are unable, despite making every reasonable effort, to obtain any medical evidence that may exist) and the individual fails or refuses, without a good reason, to attend a consultative examination (see § 404.1518); or

(3) A State agency disability hearing officer.

See § 404.1616 for the definition of medical or psychological consultant and § 404.915 for the definition of disability hearing officer. The State agency disability examiner and disability hearing officer must be qualified to interpret and evaluate medical reports and other evidence relating to the claimant's physical or mental impairments and as necessary to determine the capacities of the claimant to perform substantial gainful activity.

See § 404.1572 for what we mean by substantial gainful activity.

(d) An initial determination by the State agency that an individual is not disabled, in any case where there is evidence which indicates the existence of a mental impairment, will be made only after every reasonable effort has been made to ensure that a qualified psychiatrist or psychologist has completed the medical portion of the case review and any applicable residual functional capacity assessment. (See § 404.1616 for the qualifications we consider necessary for a psychologist to be a psychological consultant and § 404.1617 for what we mean by ''reasonable effort''.) If the services of qualified psychiatrists or psychologists cannot be obtained because of impediments at the State level, the Commissioner may contract directly for the services. In a case where there is evidence of mental and nonmental impairments and a qualified psychologist serves as a psychological consultant, the psychologist will evaluate only the mental impairment, and a physician will evaluate the nonmental impairment. The overall determination of impairment severity in combined mental and nonmental impairment cases will be made by a medical consultant and not a psychological consultant unless the mental impairment alone would justify a finding of disability.

(e) The State agency will certify each determination of disability to us on forms we provide.

(f) The State agency will furnish us with all the evidence it considered in making its determination.

(g) The State agency will not be responsible for defending in court any determination made, or any procedure formaking determinations, under these regulations.

[52 FR 33926, Sept. 9, 1987, as amended at 56 FR 11018, Mar. 14, 1991; 61 FR 11135, Mar. 19, 1996; 62 FR 38452, July 18, 1997]

§404.1616 Medical or psychological consultant.

A medical consultant must be a physician. A psychological consultant used in cases where there is evidence of a mental impairment must be a qualified psychologist. For disability program purposes a psychologist will not be considered qualified unless he or she:

(a) Is licensed or certified as a psychologist at the independent practice level of psychology by the State in which he or she practices; and

(b)(1) Possesses a doctorate degree in psychology from a program in clinical psychology of an educational institution accredited by an organization recognized by the Council on Post-Secondary Accreditation; or

(2) Is listed in a national register of health service providers in psychology which the Commissioner of Social Security deems appropriate; and

(c) Possesses 2 years of supervised clinical experience as a psychologist in health service, at least 1 year of which is post masters degree.

[52 FR 33927, Sept. 9, 1987, as amended at 62 FR 38452, July 18, 1997]

§404.1617 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.

(a) The State agency must determine if additional qualified psychiatrists and psychologists are needed to make the necessary reviews (see §404.1615(d)). Where it does not have sufficient resources to make the necessary reviews, the State agency must attempt to obtain the resources needed. If the State agency is unable to obtain additional psychiatrists and psychologists because of low salary rates or fee schedules it should attempt to raise the State agency's levels of compensation to meet the prevailing rates for psychiatrists' and psychologists' services. If these efforts are unsuccessful, the State agency will seek assistance from us. We will assist the State agency as necessary. We will also monitor the State agency's efforts and where the State agency is unable to obtain the necessary services, we will make every reasonable effort to provide the services using Federal resources.

(b) Federal resources may include the use of Federal contracts for the services of qualified psychiatrists and psychologists to review mental impairment cases. Where Federal resources are required to perform these reviews, which are a basic State agency responsibility, and where appropriate, the State agency's budget will be reduced accordingly.

(c) Where every reasonable effort is made to obtain the services of a qualified psychiatrist or psychologist to review a mental impairment case, but the professional services are not obtained, a physician who is not a psychiatrist will review the mental impairment case. For these purposes, every reasonable effort to ensure that a qualified psychiatrist or psychologist review mental impairment cases will be considered to have been made only after efforts by both State and Federal agencies as set forth in paragraphs (a) and (b) of this section are made.

[52 FR 33927, Sept. 9, 1987]

§404.1618 Notifying claimants of the disability determination.

The State agency will prepare denial notices in accordance with subpart J of this part whenever it makes a disability determination which is wholly or partly unfavorable to the claimant.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

§404.1620 General administrative requirements.

(a) The State will provide the organizational structure, qualified personnel, medical consultant services, and a quality assurance function sufficient to ensure that disability determinations are made accurately and promptly. We

may impose specific administrative requirements in these areas and in those under ''Administrative Responsibilities and Requirements'' in order to establish uniform, national administrative practices or to correct the areas of deficiencies which may later cause the State to be substantially failing to comply with our regulations or other written guidelines. We will notify the State, in writing, of the administrative requirements being imposed and of any administrative deficiencies it is required to correct. We will allow the State 90 days from the date of this notice to make appropriate corrections. Once corrected, we will monitor the State's administrative practices for 180 days. If the State does not meet the requirements or correct all of the deficiencies, or, if some of the deficiencies recur, we may initiate procedures to determine if the State is substantially failing to follow our regulations or other written guidelines.

(b) The State is responsible for making accurate and prompt disability determinations.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11018, Mar. 14, 1991]

§ 404.1621 Personnel.

(a) *Equal employment opportunity.* The State will comply with all applicable Federal statutes, executive orders and regulations concerned with equal employment opportunities.

(b) *Selection, tenure, and compensation.* The State agency will, except as may be inconsistent with paragraph (a) of this section, adhere to applicable State approved personnel standards in the selection, tenure, and compensation of any individual employed in the disability program.

(c) *Travel.* The State will make personnel available to attend meetings or workshops as may be sponsored or approved by us for furthering the purposes of the disability program.

(d) *Restrictions.* Subject to appropriate Federal funding, the State will, to the best of its ability, facilitate the processing of disability claims by avoiding personnel freezes, restrictions against overtime work, or curtailment of facilities or activities.

§ 404.1622 Training.

The State will insure that all employees have an acceptable level of competence. We will provide training and other instructional materials to facilitate basic and advanced technical proficiency of disability staff in order to insure uniformity and effectiveness in the administration of the disability program. We will conduct or specify training, as appropriate, but only if:

(a) A State agency's performance approaches unacceptable levels; or

(b) The material required for the training is complex or the capacity of the State to deliver the training is in doubt and uniformity of the training is essential.

§ 404.1623 Facilities.

(a) *Space, equipment, supplies, and other services.* Subject to appropriate Federal funding, the State will provide adequate space, equipment, supplies, and other services to facilitate making accurate and prompt disability determinations.

(b) *Location of facilities.* Subject to appropriate Federal funding, the State will determine the location where the disability determination function is to be performed so that disability determinations are made accurately and promptly.

(c) *Access.* The State will permit us access to the premises where the disability determination function is performed and also where it is managed for the purposes of inspecting and obtaining information about the work and activities required by our regulations and assuring compliance with pertinent Federal statutes and regulations. Access includes personal onsite visits and other means, such as telecommunications, of contacting the State agency to obtain information about its functions. We will contact the State agency and give reasonable prior notice of the times and purposes of any visits.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991]

§ 404.1624 Medical and other purchased services.

The State will determine the rates of payment to be used for purchasing

medical or other services necessary to make determinations of disability. The rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar type of service. The State will maintain documentation to support the rates of payment it uses.

§404.1625 Records and reports.

(a) The State will establish and maintain the records and furnish the schedules, financial, cost, and other reports relating to the administration of the disability programs as we may require.

(b) The State will permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the work which the State performs under these regulations. These records will be retained by the State for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

§404.1626 Fiscal.

(a) We will give the State funds, in advance or by way of reimbursement, for necessary costs in making disability determinations under these regulations. Necessary costs are direct as well as indirect costs as defined in 41 CFR part 1–15, subpart 1–15.7 of the Federal Procurement Regulations System for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 of the Federal Acquisition Regulations System and Federal Management Circular A–74–4[1] as amended or superseded for costs incurred after March 31, 1984.

(b) The State will submit estimates of anticipated costs in the form of a budget at the time and in the manner we require.

(c) We will notify the State of the amount which will be made available to it as well as what anticipated costs are being approved.

(d) The State may not incur or make expenditures for items of cost not approved by us or in excess of the amount we make available to the State.

(e) After the close of a period for which funds have been made available to the State, the State will submit a report of its expenditures. Based on an audit arranged by the State under Pub. L. 98–502, the Single Audit Act of 1984, or by the Inspector General of the Social Security Administration or based on an audit or review by the Social Security Administration (see §404.1627), we will determine whether the expenditures were consistent with cost principles described in 41 CFR part 1–15, subpart 1–15.7 for costs incurred before April 1, 1984; and 48 CFR part 31, subpart 31.6 and Federal Management Circular A–741–4 for costs incurred after March 31, 1984: and in other applicable written guidelines in effect at the time the expenditures were made or incurred.

(f) Any monies paid to the State which are used for purposes not within the scope of these regulations will be paid back to the Treasury of the United States.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11019, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

§404.1627 Audits.

(a) *Audits performed by the State*—(1) *Generally*. Audits of accounts and records pertaining to the administration of the disability program under the Act, will be performed by the States in accordance with the Single Audit Act of 1984 (Pub. L. 98–502) which establishes audit requirements for States receiving Federal assistance. If the audit performed by the State meets our program requirements, we will accept the findings and recommendations of the audit. The State will make every effort to act upon and resolve any items questioned in the audit.

(2) *Questioned items.* Items questioned as a result of an audit under the Single Audit Act of 1984 of a cross-cutting nature will be resolved by the Department of Health and Human Services, Office of Grant and Contract Financial Management. A cross-cutting issue is one that involves more than one Federal awarding agency. Questioned

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

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 Commissioner*—(1) *Generally.* If the State does not perform an audit under the Single Audit Act of 1984 or the audit performed is not satisfactory for disability program purposes, the books of account and records in the State pertaining to the administrations of the disability programs under the Act will be audited by the SSA's Inspector General or audited or reviewed by SSA as appropriate. These audits or reviews will be conducted to determine whether the expenditures were made for the intended purposes and in amounts necessary for the proper and efficient administration of the disability programs. Audits or reviews will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit or review.

(2) *Questioned items.* Expenditures of State agencies will be audited or reviewed, as appropriate, on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any items questioned. They will be given reasonable time to explain items questioned. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on the audit or review report.

(3) *State appeal of audit determinations.* The appropriate Social Security Administration Regional Commissioner will notify the State of his or her determination on the audit or review report. If the State disagrees with that determination, the State may request reconsideration in writing within 60 days of the date of the Regional Commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Disability, to the Commissioner of Social Security, room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. The Commissioner will make a determination and notify the State of the decision in writing no later than 90 days from the date the Social Security Administration receives the State's appeal and all supporting documents. The decision by the Commissioner on other than monetary disallowances will be final and binding upon the State. The decision by the Commissioner on monetary disallowances will be final and binding upon the State unless the State appeals the decision in writing to the Department of Health and Human Services, Departmental Appeals Board within 30 days after receiving the Commissioner's decision. See § 404.1683.

[56 FR 11019, Mar. 14, 1991, as amended at 62 FR 38452, July 18, 1997]

§ 404.1628 Property.

The State will have title to equipment purchased for disability program purposes. The State will be responsible for maintaining all property it acquires or which we furnish to it for performing the disability determination function. The State will identify the equipment by labeling and by inventory and will credit the SSA account with the fair market value of disposed property.

In the event we assume the disability determination function from a State, ownership of all property and equipment acquired with SSA funds will be transferred to us effective on the date the State is notified that we are assuming the disability determination function or we are notified that the State is terminating the relationship.

§404.1629 Participation in research and demonstration projects.

We will invite State participation in federally funded research and demonstration projects to assess the effectiveness of the disability program and to ascertain the effect of program policy changes. Where we determine that State participation is necessary for the project to be complete, for example, to provide national uniformity in a claims process, State participation is mandatory.

§404.1630 Coordination with other agencies.

(a) The State will establish cooperative working relationships with other agencies concerned with serving the disabled and, insofar as practicable, use their services, facilities, and records to:

(1) Assist the State in developing evidence and making determinations of disability; and

(2) Insure that referral of disabled or blind persons for rehabilitation services will be carried out effectively.

(b) The State may pay these agencies for the services, facilities, or records they provide. The State will include these costs in its estimates of anticipated costs and reports of actual expenditures.

§404.1631 Confidentiality of information and records.

The State will comply with the confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see §404.1633).

§404.1632 Other Federal laws and regulations.

The State will comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the disability determination function; for example, Treasury Department regulations on letters of credit (31 CFR part 205).

§404.1633 Policies and operating instructions.

(a) We will provide the State agency with written guidelines necessary for it to carry out its responsibilities in performing the disability determination function.

(b) The State agency making determinations of disability will comply with our written guidelines that are not designated as advisory or discretionary. (See §404.1602 for what we mean by written guidelines.)

(c) A representative group of State agencies will be given an opportunity to participate in formulating disability program policies that have an affect on their role in carrying out the disability determination function. State agencies will also be given an opportunity to comment before changes are made in written guidelines unless delay in issuing a change may impair service to the public.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

PERFORMANCE STANDARDS

§404.1640 General.

The following sections provide the procedures and guidelines we use to determine whether the State agency is substantially complying with our regulations and other written guidelines, including meeting established national performance standards. We use performance standards to help assure effective and uniform administration of our disability programs and to measure whether the performance of the disability determination function by each State agency is acceptable. Also, the standards are designed to improve overall State agency performance in the disability determination process and to ensure that benefits are made available to all eligible persons in an accurate and efficient manner. We measure the performance of a State agency in two areas—processing time and quality of documentation and decisions on claims. State agency compliance is also judged by State agency adherence to other program requirements.

[56 FR 11020, Mar. 14, 1991]

§404.1641 Standards of performance.

(a) *General.* The performance standards include both a target level of performance and a threshold level of performance for the State agency. The

target level represents a level of performance that we and the States will work to attain in the future. The threshold level is the minimum acceptable level of performance. Performance below the threshold level will be the basis for the Commissioner's taking from the State agency partial or complete responsibility for performing the disability determination function. Intermediate State agency goals are designed to help each State agency move from its current performance levels to the target levels.

(b) *The target level.* The target level is the optimum level of performance. There are three targets—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(c) *The threshold level.* The threshold level is the minimum acceptable level of performance. There are three thresholds—one for combined title II and title XVI initial performance accuracy, one for title II initial processing time, and one for title XVI initial processing time.

(d) *Intermediate goals.* Intermediate goals are levels of performance between the threshold levels and the target levels established by our appropriate Regional Commissioner after negotiation with each State agency. The intermediate goals are designed to help the State agencies reach the target levels. Failure to meet these goals is not a cause for considering the State agency to be substantially failing to comply with the performance standards. However, failure to meet the intermediate goals may result in consultation and an offer of optional performance support depending on the availability of our resources.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991; 62 FR 38452, July 18, 1997]

§ 404.1642 Processing time standards.

(a) *General.* Title II processing time refers to the average number of days, including Saturdays, Sundays, and holidays, it takes a State agency to process an initial disability claim from the day the case folder is received in the State agency until the day it is released to us by the State agency. Title XVI processing time refers to the average number of days, including Saturdays, Sundays, and holidays, from the day of receipt of the initial disability claim in the State agency until systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Target levels.* The processing time target levels are:

(1) 37 days for title II initial claims.

(2) 43 days for title XVI initial claims.

(c) *Threshold levels.* The processing time threshold levels are:

(1) 49.5 days for title II initial claims.

(2) 57.9 days for title XVI initial claims.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§ 404.1643 Performance accuracy standard.

(a) *General.* Performance accuracy refers to the percentage of cases that do not have to be returned to State agencies for further development or correction of decisions based on evidence in the files and as such represents the reliability of State agency adjudication. The definition of performance accuracy includes the measurement of factors that have a potential for affecting a decision, as well as the correctness of the decision. For example, if a particular item of medical evidence should have been in the file but was not included, even though its inclusion does not change the result in the case, that is a performance error. Performance accuracy, therefore, is a higher standard than decisional accuracy. As a result, the percentage of correct decisions is significantly higher than what is reflected in the error rate established by SSA's quality assurance system.

(b) *Target level.* The State agency initial performance accuracy target level for combined title II and title XVI cases is 97 percent with a corresponding decision accuracy rate of 99 percent.

(c) *Intermediate Goals.* These goals will be established annually by SSA's regional commissioner after negotiation with the State and should be used as stepping stones to progress towards our targeted level of performance.

(d) *Threshold levels.* The State agency initial performance accuracy threshold level for combined title II and title XVI cases is 90.6 percent.

§404.1644 How and when we determine whether the processing time standards are met.

(a) *How we determine processing times.* For all initial title II cases, we calculate the mean number of days, including Saturdays, Sundays and holidays, from the day the case folder is received in the State agency until the day it is released to us by the State agency. For initial title XVI cases, we calculate the mean number of days, including Saturdays, Sundays, and holidays, from the day the case folder is received in the State agency until the day there is a systems input of a presumptive disability decision or the day the case folder is released to us by the State agency, whichever is earlier.

(b) *Frequency of review.* Title II processing times and title XVI processing times are monitored separately on a quarterly basis. The determination as to whether or not the processing time thresholds have been met is made at the end of each quarter each year. Quarterly State-by-State mean processing times are compared with the threshold levels for both title II and title XVI.

[46 FR 29204, May 29, 1981, as amended at 56 FR 11020, Mar. 14, 1991]

§404.1645 How and when we determine whether the performance accuracy standard is met.

(a) *How we determine performance accuracy.* We determine a State agency's performance accuracy rate on the basis of decision and documentation errors identified in our review of the sample cases.

(b) *Frequency of review.* Title II and title XVI initial performance accuracy are monitored together on a quarterly basis. The determinations as to whether the performance accuracy threshold has been met is made at the end of each quarter each year. Quarterly State-by-State combined initial performance accuracy rates are compared to the established threshold level.

§404.1650 Action we will take if a State agency does not meet the standards.

If a State agency does not meet two of the three established threshold levels (one of which must be performance accuracy) for two or more consecutive calendar quarters, we will notify the State agency in writing that it is not meeting the standards. Following our notification, we will provide the State agency appropriate performance support described in §§404.1660, 404.1661 and 404.1662 for a period of up to 12 months.

[56 FR 11020, Mar. 14, 1991]

PERFORMANCE MONITORING AND SUPPORT

§404.1660 How we will monitor.

We will regularly analyze State agency combined title II and title XVI initial performance accuracy rate, title II initial processing time, and title XVI initial processing time. Within budgeted resources, we will also routinely conduct fiscal and administrative management reviews and special onsite reviews. A fiscal and administrative management review is a fact-finding mission to review particular aspects of State agency operations. During these reviews we will also review the quality assurance function. This regular monitoring and review program will allow us to determine the progress each State is making and the type and extent of performance support we will provide to help the State progress toward threshold, intermediate, and/or target levels.

[56 FR 11020, Mar. 14, 1991]

§404.1661 When we will provide performance support.

(a) *Optional support.* We may offer, or a State may request, performance support at any time that the regular monitoring and review process reveals that support could enhance performance. The State does not have to be below the initial performance accuracy rate of 90.6 percent to receive performance support. Support will be offered, or granted upon request, based on available resources.

(b) *Mandatory support.* (1) We will provide a State agency with mandatory

performance support if regular monitoring and review reveal that two of three threshold levels (one of which must be performance accuracy) are not met for two consecutive calendar quarters.

(2) We may also decide to provide a State agency with mandatory performance support if regular monitoring and review reveal that any one of the three threshold levels is not met for two consecutive calendar quarters. Support will be provided based on available resources.

(3) The threshold levels are:

(i) Combined title II and title XVI initial performance accuracy rate—90.6 percent,

(ii) Title II initial processing time—49.5 days, and

(iii) Title XVI initial processing time—57.9 days.

[56 FR 11020, Mar. 14, 1991]

§ 404.1662 What support we will provide.

Performance support may include, but is not limited to, any or all of the following:

(a) An onsite review of cases processed by the State agency emphasizing adherence to written guidelines.

(b) A request that necessary administrative measures be implemented (e.g., filling staffing vacancies, using overtime, assisting with training activities, etc.).

(c) Provisions for Federal personnel to perform onsite reviews, conduct training, or perform other functions needed to improve performance.

(d) Provisions for fiscal aid to allow for overtime, temporary hiring of additional staff, etc., above the authorized budget.

[56 FR 11020, Mar. 14, 1991]

SUBSTANTIAL FAILURE

§ 404.1670 General.

After a State agency falls below two of three established threshold levels, one being performance accuracy, for two consecutive quarters, and after the mandatory performance support period, we will give the State agency a 3-month adjustment period. During this 3-month period we will not require the State agency to meet the threshold levels. Following the adjustment period, if the State agency again falls below two of three threshold levels, one being performance accuracy, in two consecutive quarters during the next 12 months, we will notify the State that we propose to find that the State agency has substantially failed to comply with our standards and advise it that it may request a hearing on that issue. After giving the State notice and an opportunity for a hearing, if it is found that a State agency has substantially failed to make disability determinations consistent with the Act, our regulations or other written guidelines, we will assume partial or complete responsibility for performing the disability determination function after we have complied with §§ 404.1690 and 404.1692.

[56 FR 11021, Mar. 14, 1991]

§ 404.1671 Good cause for not following the Act, our regulations, or other written guidelines.

If a State has good cause for not following the Act, our regulations, or other written guidelines, we will not find that the State agency has substantially failed to meet our standards. We will determine if good cause exists. Some of the factors relevant to good cause are:

(a) Disasters such as fire, flood, or civil disorder, that—

(1) Require the diversion of significant personnel normally assigned to the disability determination function, or

(2) Destroyed or delayed access to significant records needed to make accurate disability determinations;

(b) Strikes of State agency staff or other government or private personnel necessary to the performance of the disability determination function;

(c) Sudden and unanticipated workload changes which result from changes in Federal law, regulations, or written guidelines, systems modification or systems malfunctions, or rapid, unpredictable caseload growth for a 6-month period or longer.

[56 FR 11021, Mar. 14, 1991]

§404.1675 Finding of substantial failure.

A finding of substantial failure with respect to a State may not be made unless and until the State is afforded an opportunity for a hearing.

HEARINGS AND APPEALS

§404.1680 Notice of right to hearing on proposed finding of substantial failure.

If, following the mandatory performance support period and the 3-month adjustment period, a State agency again falls below two of three threshold levels (one being performance accuracy) in two consecutive quarters in the succeeding 12 months, we will notify the State in writing that we will find that the State agency has substantially failed to meet our standards unless the State submits a written request for a hearing with the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving the notice. The notice will identify the threshold levels that were not met by the State agency, the period during which the thresholds were not met and the accuracy and processing time levels attained by the State agency during this period. If a hearing is not requested, the State agency will be found to have substantially failed to meet our standards, and we will implement our plans to assume the disability determination function.

[56 FR 11021, Mar. 14, 1991]

§404.1681 Disputes on matters other than substantial failure.

Disputes concerning monetary disallowances will be resolved in proceedings before the Department of Health and Human Services' Departmental Appeals Board if the issue cannot be resolved between us and the State. Disputes other than monetary disallowances will be resolved through an appeal to the Commissioner of Social Security, who will make the final decision. (See §404.1627.)

[56 FR 11021, Mar. 14, 1991]

§404.1682 Who conducts the hearings.

If a hearing is required, it will be conducted by the Department of Health and Human Services' Grant Appeals Board (the Board).

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§404.1683 Hearings and appeals process.

The rules for hearings and appeals before the Board are provided in 45 CFR part 16. A notice under §404.1680 of this subpart will be considered a ''final written decision'' for purposes of Board review.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

§404.1690 Assumption when we make a finding of substantial failure.

(a) *Notice to State.* When we find that substantial failure exists, we will notify the State in writing that we will assume responsibility for performing the disability determination function from the State agency, whether the assumption will be partial or complete, and the date on which the assumption will be effective.

(b) *Effective date of assumption.* The date of any partial or complete assumption of the disability determination function from a State agency may not be earlier than 180 days after our finding of substantial failure, and not before compliance with the requirements of §404.1692.

§404.1691 Assumption when State no longer wishes to perform the disability determination function.

(a) *Notice to the Commissioner.* If a State no longer wishes to perform the disability determination function, it will notify us in writing. The notice must be from an official authorized to act for the State for this purpose. The State will provide an opinion from the State's Attorney General verifying the authority of the official who gave the notice.

(b) *Effective date of assumption.* The State agency will continue to perform whatever activities of the disability determination function it is performing at the time the notice referred to in paragraph (a) of this section is given for not less than 180 days or, if later, until we have complied with the requirements of §404.1692. For example, if

the State is not making disability determinations (because we previously assumed responsibility for making them) but is performing other activities related to the disability determination function at the time it gives notice, the State will continue to do these activities until the requirements of this paragraph are met. Thereafter, we will assume complete responsibility for performing the disability determination function.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

§ 404.1692 Protection of State employees.

(a) *Hiring preference.* We will develop and initiate procedures to implement a plan to partially or completely assume the disability determination function from the State agency under § 404.1690 or § 404.1691, as appropriate. Except for the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent), we will give employees of the State agency who are capable of performing duties in the disability determination function preference over any other persons in filling positions with us for which they are qualified. We may also give a preference in hiring to the State agency's administrator, deputy administrator, or assistant administrator (or his equivalent). We will establish a system for determining the hiring priority among the affected State agency employees in those instances where we are not hiring all of them.

(b) *Determination by Secretary of Labor.* We will not assume responsibility for performing the disability determination function from a State until the Secretary of Labor determines that the State has made fair and equitable arrangements under applicable Federal, State and local law to protect the interests of employees who will be displaced from their employment because of the assumption and who we will not hire.

§ 404.1693 Limitation on State expenditures after notice.

The State agency may not, after it receives the notice referred to in § 404.1690, or gives the notice referred to in § 404.1691, make any new commitments to spend funds allocated to it for performing the disability determination function without the approval of the appropriate SSA regional commissioner. The State will make every effort to close out as soon as possible all existing commitments that relate to performing the disability determination function.

§ 404.1694 Final accounting by the State.

The State will submit its final claims to us as soon as possible, but in no event later than 1 year from the effective date of our assumption of the disability determination function unless we grant an extension of time. When the final claim(s) is submitted, a final accounting will be made by the State of any funds paid to the State under § 404.1626 which have not been spent or committed prior to the effective date of our assumption of the disability determination function. Disputes concerning final accounting issues which cannot be resolved between the State and us will be resolved in proceedings before the Departmental Appeals Board as described in 45 CFR part 16.

[46 FR 29204, May 29, 1981, as amended at 62 FR 38452, July 18, 1997]

Subpart R—Representation of Parties

AUTHORITY: Secs. 205(a), 206, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 406, and 902(a)(5)).

SOURCE: 45 FR 52090, Aug. 5, 1980, unless otherwise noted.

§ 404.1700 Introduction.

You may appoint someone to represent you in any of your dealings with us. This subpart explains, among other things—

(a) Who may be your representative and what his or her qualifications must be;

(b) How you appoint a representative;

(c) The payment of fees to a representative;

(d) Our rules that representatives must follow; and

(e) What happens to a representative who breaks the rules.

§404.1703 Definitions.

As used in this subpart—

Past-due benefits means the total amount of benefits payable under title II of the Act to all beneficiaries that has accumulated because of a favorable administrative or judicial determination or decision, up to but not including the month the determination or decision is made.

Representative means an attorney who meets all of the requirements of §404.1705(a), or a person other than an attorney who meets all of the requirements of §404.1705(b), and whom you appoint to represent you in dealings with us.

We, our, or *us* refers to the Social Security Administration.

You or *your* refers to any person claiming a right under the old-age, disability, dependents', or survivors' benefits program.

§404.1705 Who may be your representative.

(a) *Attorney.* You may appoint as your representative in dealings with us, any attorney in good standing who—

(1) Has the right to practice law before a court of a State, Territory, District, or island possession of the United States, or before the Supreme Court or a lower Federal court of the United States;

(2) Is not disqualified or suspended from acting as a representative in dealings with us; and

(3) Is not prohibited by any law from acting as a representative.

(b) *Person other than attorney.* You may appoint any person who is not an attorney to be your representative in dealings with us if he or she—

(1) Is generally known to have a good character and reputation;

(2) Is capable of giving valuable help to you in connection with your claim;

(3) Is not disqualified or suspended from acting as a representative in dealings with us; and

(4) Is not prohibited by any law from acting as a representative.

§404.1706 Notification of options for obtaining attorney representation.

If you are not represented by an attorney and we make a determination or decision that is subject to the administrative review process provided under subpart J of this part and it does not grant all of the benefits or other relief you requested or it adversely affects any entitlement to benefits that we have established or may establish for you, we will include with the notice of that determination or decision information about your options for obtaining an attorney to represent you in dealing with us. We will also tell you that a legal services organization may provide you with legal representation free of charge if you satisfy the qualifying requirements applicable to that organization.

[58 FR 64886, Dec. 10, 1993]

§404.1707 Appointing a representative.

We will recognize a person as your representative if the following things are done:

(a) You sign a written notice stating that you want the person to be your representative in dealings with us.

(b) That person signs the notice, agreeing to be your representative, if the person is not an attorney. An attorney does not have to sign a notice of appointment.

(c) The notice is filed at one of our offices if you have initially filed a claim or have requested reconsideration; with an administrative law judge if you requested a hearing; or with the Appeals Council if you have requested a review of the administrative law judge's decision.

§404.1710 Authority of a representative.

(a) *What a representative may do.* Your representative may, on your behalf—

(1) Obtain information about your claim to the same extent that you are able to do;

(2) Submit evidence;

(3) Make statements about facts and law; and

(4) Make any request or give any notice about the proceedings before us.

(b) *What a representative may not do.* A representative may not sign an application on behalf of a claimant for rights or benefits under title II of the Act unless authorized to do so under §404.612.

§ 404.1715 Notice or request to a representative.

(a) We shall send your representative—

(1) Notice and a copy of any administrative action, determination, or decision; and

(2) Requests for information or evidence.

(b) A notice or request sent to your representative, will have the same force and effect as if it had been sent to you.

§ 404.1720 Fee for a representative's services.

(a) *General.* A representative may charge and receive a fee for his or her services as a representative only as provided in paragraph (b) of this section.

(b) *Charging and receiving a fee.* (1) The representative must file a written request with us before he or she may charge or receive a fee for his or her services.

(2) We decide the amount of the fee, if any, a representative may charge or receive.

(3) A representative shall not charge or receive any fee unless we have approved it, and he or she shall not charge or receive any fee that is more than the amount we approve. This rule applies whether the fee is charged to or received from you or from someone else.

(4) If the representative is an attorney and the claimant is entitled to past-due benefits, we will pay the authorized fee, or a part of the authorized fee, directly to the attorney out of the past-due benefits, subject to the limitations described in § 404.1730(b)(1). If the representative is not an attorney, we assume no responsibility for the payment of any fee that we have authorized.

(c) *Notice of fee determination.* We shall mail to both you and your representative at your last known address a written notice of what we decide about the fee. We shall state in the notice—

(1) The amount of the fee that is authorized;

(2) How we made that decision;

(3) That we are not responsible for paying the fee, except when we may pay an attorney from past-due benefits; and

(4) That within 30 days of the date of the notice, either you or your representative may request us to review the fee determination.

(d) *Review of fee determination*—(1) *Request filed on time.* We will review the decision we made about a fee if either you or your representative files a written request for the review at one of our offices within 30 days after the date of the notice of the fee determination. Either you or your representative, whoever requests the review, shall mail a copy of the request to the other person. An authorized official of the Social Security Administration who did not take part in the fee determination being questioned will review the determination. This determination is not subject to further review. The official shall mail a written notice of the decision made on review both to you and to your representative at your last known address.

(2) *Request not filed on time.* (i) If you or your representative requests a review of the decision we made about a fee, but does so more than 30 days after the date of the notice of the fee determination, whoever makes the request shall state in writing why it was not filed within the 30-day period. We will review the determination if we decide that there was good cause for not filing the request on time.

(ii) Some examples of good cause follow:

(A) Either you or your representative was seriously ill and the illness prevented you or your representative from contacting us in person or in writing.

(B) There was a death or serious illness in your family or in the family of your representative.

(C) Material records were destroyed by fire or other accidental cause.

(D) We gave you or your representative incorrect or incomplete information about the right to request review.

(E) You or your representative did not timely receive notice of the fee determination.

(F) You or your representative sent the request to another government agency in good faith within the 30-day period, and the request did not reach us until after the period had ended.

(3) *Payment of fees.* We assume no responsibility for the payment of a fee based on a revised determination if the request for administrative review was not filed on time.

§404.1725 Request for approval of a fee.

(a) *Filing a request.* In order for your representative to obtain approval of a fee for services he or she performed in dealings with us, he or she shall file a written request with one of our offices. This should be done after the proceedings in which he or she was a representative are completed. The request must contain—

(1) The dates the representative's services began and ended;

(2) A list of the services he or she gave and the amount of time he or she spent on each type of service;

(3) The amount of the fee he or she wants to charge for the services;

(4) The amount of fee the representative wants to request or charge for his or her services in the same matter before any State or Federal court;

(5) The amount of and a list of any expenses the representative incurred for which he or she has been paid or expects to be paid;

(6) A description of the special qualifications which enabled the representative, if he or she is not an attorney, to give valuable help in connection with your claim; and

(7) A statement showing that the representative sent a copy of the request for approval of a fee to you.

(b) *Evaluating a request for approval of a fee.* (1) When we evaluate a representative's request for approval of a fee, we consider the purpose of the social security program, which is to provide a measure of economic security for the beneficiaries of the program, together with—

(i) The extent and type of services the representative performed;

(ii) The complexity of the case;

(iii) The level of skill and competence required of the representative in giving the services;

(iv) The amount of time the representative spent on the case;

(v) The results the representative achieved;

(vi) The level of review to which the claim was taken and the level of the review at which the representative became your representative; and

(vii) The amount of fee the representative requests for his or her services, including any amount authorized or requested before, but not including the amount of any expenses he or she incurred.

(2) Although we consider the amount of benefits, if any, that are payable, we do not base the amount of fee we authorize on the amount of the benefit alone, but on a consideration of all the factors listed in this section. The benefits payable in any claim are determined by specific provisions of law and are unrelated to the efforts of the representative. We may authorize a fee even if no benefits are payable.

§404.1728 Proceedings before a State or Federal court.

(a) *Representation of a party in court proceedings.* We shall not consider any service the representative gave you in any proceeding before a State or Federal court to be services as a representative in dealings with us. However, if the representative also has given service to you in the same connection in any dealings with us, he or she must specify what, if any, portion of the fee he or she wants to charge is for services performed in dealings with us. If the representative charges any fee for those services, he or she must file the request and furnish all of the information required by §404.1725.

(b) *Attorney fee allowed by a Federal court.* If a Federal court in any proceeding under title II of the Act makes a judgment in favor of a claimant who was represented before the court by an attorney, and the court, under section 206(b) of the Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is entitled by reason of the judgment, we may pay the attorney the amount of the fee out of, but not in addition to, the amount of the past-due benefits payable. We will not certify for direct payment any other fee your representative may request.

§ 404.1730 Payment of fees.

(a) *Fees allowed by a Federal court.* We will pay a representative who is an attorney, out of the claimant's past-due benefits, the amount of fee allowed by a Federal court in a proceeding under title II of the Act. The payment we make to the attorney is subject to the limitations described in paragraph (b)(1) of this section.

(b) *Fees we may authorize*—(1) *Attorneys.* Except as provided in paragraph (c) of this section, if we make a determination or decision in favor of a claimant who was represented by an attorney, and as a result of the determination or decision past-due benefits are payable, we will pay the attorney out of the past-due benefits the smallest of—

(i) Twenty-five percent of the total of the past-due benefits;

(ii) The amount of the fee that we set; or

(iii) The amount agreed upon between the attorney and the claimant represented.

(2) *Persons other than attorneys.* If the representative is not an attorney, we assume no responsibility for the payment of any fee that we have authorized. We will not deduct the fee from any benefits payable to the claimant represented.

(c) *Time limit for filing request for approval of attorney fee.* (1) In order to receive direct payment of a fee from a claimant's past-due benefits, an attorney should file a request for approval of a fee, or written notice of the intent to file a request, at one of our offices within 60 days of the date the notice of the favorable determination is mailed.

(2)(i) If no request is filed within 60 days of the date the notice of the favorable determination is mailed, we will mail a written notice to the attorney and to the claimant, at their last known addresses. The notice will inform the attorney and the claimant that unless the attorney files, within 20 days from the date of the notice, a written request for approval of a fee under § 404.1725, or a written request for an extension of time, we will pay all the past-due benefits to the claimant.

(ii) The attorney must send the claimant a copy of any request made to us for an extension of time. If the request is not filed within 20 days of the date of the notice, or by the last day of any extension we approved, we will pay all past-due benefits to the claimant. Any fee the attorney charges after that time must be approved by us, but the collection of any approved fee is a matter between the attorney and the claimant represented.

§ 404.1735 Services in a proceeding under title II of the Act.

Services provided a claimant in any dealing with us under title II of the Act consist of services performed for that claimant in connection with any claim he or she may have before the Commissioner of Social Security under title II of the Act. These services include any in connection with any asserted right a claimant may have calling for an initial or reconsidered determination by us, and a decision or action by an administrative law judge or by the Appeals Council.

[45 FR 52090, Aug. 5, 1980, as amended at 62 FR 38452, July 18, 1997]

§ 404.1740 Rules of conduct and standards of responsibility for representatives.

(a) *Purpose and scope.* (1) All attorneys or other persons acting on behalf of a party seeking a statutory right or benefit shall, in their dealings with us, faithfully execute their duties as agents and fiduciaries of a party. A representative shall provide competent assistance to the claimant and recognize the authority of the Agency to lawfully administer the process. The following provisions set forth certain affirmative duties and prohibited actions which shall govern the relationship between the representative and the Agency, including matters involving our administrative procedures and fee collections.

(2) All representatives shall be forthright in their dealings with us and with the claimant and shall comport themselves with due regard for the nonadversarial nature of the proceedings by complying with our rules and standards, which are intended to ensure orderly and fair presentation of evidence and argument.

(b) *Affirmative duties.* A representative shall, in conformity with the regulations setting forth our existing duties and responsibilities and those of claimants (see §404.1512 in disability and blindness claims):

(1) Act with reasonable promptness to obtain the information and evidence that the claimant wants to submit in support of his or her claim, and forward the same to us for consideration as soon as practicable. In disability and blindness claims, this includes the obligations to assist the claimant in bringing to our attention everything that shows that the claimant is disabled or blind, and to assist the claimant in furnishing medical evidence that the claimant intends to personally provide and other evidence that we can use to reach conclusions about the claimant's medical impairment(s) and, if material to the determination of whether the claimant is blind or disabled, its effect upon the claimant's ability to work on a sustained basis, pursuant to §404.1512(a);

(2) Assist the claimant in complying, as soon as practicable, with our requests for information or evidence at any stage of the administrative decisionmaking process in his or her claim. In disability and blindness claims, this includes the obligation pursuant to §404.1512(c) to assist the claimant in providing, upon our request, evidence about:

(i) The claimant's age;

(ii) The claimant's education and training;

(iii) The claimant's work experience;

(iv) The claimant's daily activities both before and after the date the claimant alleges that he or she became disabled;

(v) The claimant's efforts to work; and

(vi) Any other factors showing how the claimant's impairment(s) affects his or her ability to work. In §§404.1560 through 404.1569, we discuss in more detail the evidence we need when we consider vocational factors; and

(3) Conduct his or her dealings in a manner that furthers the efficient, fair and orderly conduct of the administrative decisionmaking process, including duties to:

(i) Provide competent representation to a claimant. Competent representation requires the knowledge, skill, thoroughness and preparation reasonably necessary for the representation. This includes knowing the significant issue(s) in a claim and having a working knowledge of the applicable provisions of the Social Security Act, as amended, the regulations and the Rulings; and

(ii) Act with reasonable diligence and promptness in representing a claimant. This includes providing prompt and responsive answers to requests from the Agency for information pertinent to processing of the claim.

(c) *Prohibited actions.* A representative shall not:

(1) In any manner or by any means threaten, coerce, intimidate, deceive or knowingly mislead a claimant, or prospective claimant or beneficiary, regarding benefits or other rights under the Act;

(2) Knowingly charge, collect or retain, or make any arrangement to charge, collect or retain, from any source, directly or indirectly, any fee for representational services in violation of applicable law or regulation;

(3) Knowingly make or present, or participate in the making or presentation of, false or misleading oral or written statements, assertions or representations about a material fact or law concerning a matter within our jurisdiction;

(4) Through his or her own actions or omissions, unreasonably delay or cause to be delayed, without good cause (see §404.911(b)), the processing of a claim at any stage of the administrative decisionmaking process;

(5) Divulge, without the claimant's consent, except as may be authorized by regulations prescribed by us or as otherwise provided by Federal law, any information we furnish or disclose about a claim or prospective claim;

(6) Attempt to influence, directly or indirectly, the outcome of a decision, determination or other administrative action by offering or granting a loan, gift, entertainment or anything of value to a presiding official, Agency employee or witness who is or may reasonably be expected to be involved in the administrative decisionmaking

process, except as reimbursement for legitimately incurred expenses or lawful compensation for the services of an expert witness retained on a non-contingency basis to provide evidence; or

(7) Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings, including but not limited to:

(i) Repeated absences from or persistent tardiness at scheduled proceedings without good cause (see § 404.911(b));

(ii) Willful behavior which has the effect of improperly disrupting proceedings or obstructing the adjudicative process; and

(iii) Threatening or intimidating language, gestures or actions directed at a presiding official, witness or Agency employee which results in a disruption of the orderly presentation and reception of evidence.

[63 FR 41416, Aug. 4, 1998]

§ 404.1745 Violations of our requirements, rules, or standards.

When we have evidence that a representative fails to meet our qualification requirements or has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us. We may file charges seeking such sanctions when we have evidence that a representative:

(a) Does not meet the qualifying requirements described in § 404.1705;

(b) Has violated the affirmative duties or engaged in the prohibited actions set forth in § 404.1740; or

(c) Has been convicted of a violation under section 206 of the Act.

[63 FR 41416, Aug. 4, 1998]

§ 404.1750 Notice of charges against a representative.

(a) The Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), 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 Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee, may extend the 30-day period for good cause.

(e) The representative must—

(1) Answer the notice in writing under oath (or affirmation); and

(2) File the answer with the Social Security Administration, Office of Hearings and Appeals, Attention: Special Counsel Staff, within the 30-day time period.

(f) If the representative does not file an answer within the 30-day time period, he or she does not have the right to present evidence, except as may be provided in § 404.1765(g).

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24131, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998]

§ 404.1755 Withdrawing charges against a representative.

We may withdraw charges against a representative. We will do this if the representative files an answer, or we obtain evidence, that satisfies us that there is reasonable doubt about whether he or she should be suspended or disqualified from acting as a representative in dealings with us. If we withdraw the charges, we shall notify the representative by mail at his or her last known address.

§ 404.1765 Hearing on charges.

(a) *Scheduling the hearing.* If the Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee, does not take action to withdraw the charges within 15 days after the date on which the representative filed an answer, we will hold a hearing and make a decision on the charges.

(b)(1) *Hearing officer.* The Associate Commissioner for Hearings and Appeals, or his or her designee, shall assign an administrative law judge, designated to act as a hearing officer, to hold a hearing on the charges.

(2) No hearing officer shall hold a hearing in a case in which he or she is prejudiced or partial about any party, or has any interest in the matter.

(3) If the representative or any party to the hearing objects to the hearing officer who has been named to hold the hearing, we must be notified at the earliest opportunity. The hearing officer shall consider the objection(s) and either proceed with the hearing or withdraw from it.

(4) If the hearing officer withdraws from the hearing, another one will be named.

(5) If the hearing officer does not withdraw, the representative or any other person objecting may, after the hearing, present his or her objections to the Appeals Council explaining why he or she believes the hearing officer's decision should be revised or a new hearing held by another administrative law judge designated to act as a hearing officer.

(c) *Time and place of hearing.* The hearing officer shall mail the parties a written notice of the hearing at their last known addresses, at least 20 days before the date set for the hearing.

(d) *Change of time and place for hearing.* (1) The hearing officer may change the time and place for the hearing. This may be done either on his or her own initiative, or at the request of the representative or the other party to the hearing.

(2) The hearing officer may adjourn or postpone the hearing.

(3) The hearing officer may reopen the hearing for the receipt of additional evidence at any time before mailing notice of the decision.

(4) The hearing officer shall give the representative and the other party to the hearing reasonable notice of any change in the time or place for the hearing, or of an adjournment or reopening of the hearing.

(e) *Parties.* The representative against whom charges have been made is a party to the hearing. The Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), 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 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 52090, Aug. 5, 1980, as amended at 56 FR 24131, 24132, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998]

§ 404.1770 Decision by hearing officer.

(a) *General.* (1) After the close of the hearing, the hearing officer shall issue a decision or certify the case to the Appeals Council. The decision must be in writing, will contain findings of fact and conclusions of law, and be based upon the evidence of record.

(2) If the hearing officer finds that the charges against the representative have been sustained, he or she shall either—

(i) Suspend the representative for a specified period of not less than 1 year, nor more than 5 years, from the date of the decision; or

(ii) Disqualify the representative from acting as a representative in dealings with us until he or she may be reinstated under § 404.1799.

(3) The hearing officer shall mail a copy of the decision to the 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 §404.1799.

(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 §404.1799.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 63 FR 41417, Aug. 4, 1998]

§404.1775 Requesting review of the hearing officer's decision.

(a) *General.* After the hearing officer issues a decision, either the representative or the other party to the hearing may ask the Appeals Council to review the decision.

(b) *Time and place of filing request for review.* The party requesting review shall file the request for review in writing with the Appeals Council within 30 days from the date the hearing officer mailed the notice. The party requesting review shall certify that a copy of the request for review and of any documents that are submitted have been mailed to the opposing party.

§404.1776 Assignment of request for review of the hearing officer's decision.

Upon receipt of a request for review of the hearing officer's decision, the matter will be assigned to a panel consisting of three members of the Appeals Council none of whom shall be the Chair of the Appeals Council. The panel shall jointly consider and rule by majority opinion on the request for review of the hearing officer's decision, including a determination to dismiss the request for review. Matters other than a final disposition of the request for review may be disposed of by the member designated chair of the panel.

[56 FR 24132, May 29, 1991]

§404.1780 Appeals Council's review of hearing officer's decision.

(a) Upon request, the Appeals Council shall give the parties a reasonable time to file briefs or other written statements as to fact and law, and to appear before the Appeals Council to present oral argument.

(b) If a party files a brief or other written statement with the Appeals Council, he or she shall send a copy to the opposing party and certify that the copy has been sent.

§404.1785 Evidence permitted on review.

(a) *General.* Generally, the Appeals Council will not consider evidence in addition to that introduced at the hearing. However, if the Appeals Council believes that the evidence offered is material to an issue it is considering, the evidence will be considered.

(b) *Individual charged filed an answer.* (1) When the Appeals Council believes that additional material evidence is available, and the representative has filed an answer to the charges, the Appeals Council shall require that the evidence be obtained. The Appeals Council may name an administrative law judge or a member of the Appeals Council to receive the evidence.

(2) Before additional evidence is admitted into the record, the Appeals Council shall mail a notice to the parties, telling them that evidence about certain issues will be obtained, unless the notice is waived. The Appeals Council shall give each party a reasonable opportunity to comment on the evidence and to present other evidence that is material to an issue it is considering.

(c) *Individual charged did not file an answer.* If the representative did not file an answer to the charges, the Appeals Council will not permit the introduction of evidence that was not considered at the hearing.

§404.1790 Appeals Council's decision.

(a) The Appeals Council shall base its decision upon the evidence in the hearing record and any other evidence it may permit on review. The Appeals Council shall either—

(1) Affirm, reverse, or modify the hearing officer's decision; or

(2) Return a case to the hearing officer when the Appeals Council considers it appropriate.

(b) The Appeals Council, in changing a hearing officer's decision to suspend a representative for a specified period,

shall in no event reduce the period of suspension to less than 1 year. In modifying a hearing officer's decision to disqualify a representative, the Appeals Council shall in no event impose a period of suspension of less than 1 year.

(c) If the Appeals Council affirms or changes a hearing officer's decision, the period of suspension or the disqualification is effective from the date of the Appeals Council's decision.

(d) If the hearing officer did not impose a period of suspension or a disqualification, and the Appeals Council decides to impose one or the other, the suspension or disqualification is effective from the date of the Appeals Council's decision.

(e) The Appeals Council shall make its decision in writing and shall mail a copy of the decision to the parties at their last known addresses.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991]

§ 404.1795 When the Appeals Council will dismiss a request for review.

The Appeals Council may dismiss a request for the review of any proceeding to suspend or disqualify a representative in any of the following circumstances:

(a) *Upon request of party*. The Appeals Council may dismiss a request for review upon written request of the party or parties who filed the request if there is no other party who objects to the dismissal.

(b) *Death of party*. The Appeals Council may dismiss a request for review in the event of the death of the representative.

(c) *Request for review not timely filed*. The Appeals Council will dismiss a request for review if a party failed to file a request for review within the 30-day time period and the Appeals Council does not extend the time for good cause.

§ 404.1797 Reinstatement after suspension—period of suspension expired.

We shall automatically allow a person to serve again as a representative in dealings with us at the end of any suspension.

§ 404.1799 Reinstatement after suspension or disqualification—period of suspension not expired.

(a) After more than one year has passed, a person who has been suspended or disqualified, may ask the Appeals Council for permission to serve as a representative again.

(b) The suspended or disqualified person shall submit any evidence he or she wishes to have considered along with the request to be allowed to serve as a representative again.

(c) The Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee, upon notification of receipt of the request, shall have 30 days in which to present a written report of any experiences with the suspended or disqualified person subsequent to that person's suspension or disqualification. The Appeals Council shall make available to the suspended or disqualified person a copy of the report.

(d) The Appeals Council shall not grant the request unless it is reasonably satisfied that the person will in the future act according to the provisions of section 206(a) of the Act, and to our rules and regulations.

(e) The Appeals Council shall mail a notice of its decision on the decision to the suspended or disqualified person. It shall also mail a copy to the Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee.

(f) If the Appeals Council decides not to grant the request, it shall not consider another request before the end of 1 year from the date of the notice of the previous denial.

[45 FR 52090, Aug. 5, 1980, as amended at 56 FR 24132, May 29, 1991; 62 FR 38452, July 18, 1997; 63 FR 41417, Aug. 4, 1998]

Subpart S—Payment Procedures

AUTHORITY: Secs. 205 (a) and (n), 207, 702(a)(5), and 708(a) of the Social Security Act (42 U.S.C. 405 (a) and (n), 407, 902(a)(5) and 909(a)).

SOURCE: 45 FR 52095, Aug. 5, 1980, unless otherwise noted.

§404.1800 Introduction.

After we have made a determination or decision that you are entitled to benefits under title II of the Act, we begin paying those benefits to you as soon as possible. This subpart explains—

(a) What we must do so that your benefits begin promptly;

(b) When and how you may request that payment of benefits be expedited;

(c) When we may cause your benefits to be withheld;

(d) Our obligation not to assign or transfer your benefits to someone; and

(e) When we will use one check to pay benefits to two or more persons in a family.

§404.1805 Paying benefits.

(a) As soon as possible after we have made a determination or decision that you are entitled to benefits, we certify to the Secretary of the Treasury, who is the Managing Trustee of the Trust Funds—

(1) Your name and address, or the name and address of the person to be paid if someone receives your benefits on your behalf as a representative payee;

(2) The amount of the payment or payments to be made from the appropriate Trust Fund; and

(3) The time at which the payment or payments should be made in accordance with §404.1807.

(b) Under certain circumstances when you have had railroad employment, we will certify the information to the Railroad Retirement Board.

[45 FR 52095, Aug. 5, 1980, as amended at 62 FR 6120, Feb. 11, 1997]

§404.1807 Monthly payment day.

(a) *General.* Once we have made a determination or decision that you are entitled to recurring monthly benefits, you will be assigned a monthly payment day. Thereafter, any recurring monthly benefits which are payable to you will be certified to the Managing Trustee for delivery on or before that day of the month as part of our certification under §404.1805(a)(3). Except as provided in paragraphs (c)(2) through (c)(6) of this section, once you have been assigned a monthly payment day, that day will not be changed.

(b) *Assignment of payment day.* (1) We will assign the same payment day for all individuals who receive benefits on the earnings record of a particular insured individual.

(2) The payment day will be selected based on the day of the month on which the insured individual was born. Insured individuals born on the 1st through the 10th of the month will be paid on the second Wednesday of each month. Insured individuals born on the 11th through the 20th of the month will be paid on the third Wednesday of each month. Insured individuals born after the 20th of the month will be paid on the fourth Wednesday of each month. See paragraph (c) of this section for exceptions.

(3) We will notify you in writing of the particular monthly payment day that is assigned to you.

(c) *Exceptions.* (1) If you or any other person became entitled to benefits on the earnings record of the insured individual based on an application filed before May 1, 1997, you will continue to receive your benefits on the 3rd day of the month (but see paragraph (c)(6) of this section). All persons who subsequently become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day.

(2) If you or any other person become entitled to benefits on the earnings record of the insured individual based on an application filed after April 30, 1997, and also become entitled to Supplemental Security Income (SSI) benefits or have income which is deemed to an SSI beneficiary (per §416.1160), all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(3) If you or any other person become entitled to benefits on the earnings record of the insured individual based on an application filed after April 30, 1997, and also reside in a foreign country, all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day

of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(4) If you or any other person become entitled on the earnings record of the insured individual based on an application filed after April 30, 1997, and are not entitled to SSI but are or become eligible for the State where you live to pay your Medicare premium under the provisions of section 1843 of the Act, all persons who are or become entitled to benefits on that earnings record will be assigned to the 3rd day of the month as the monthly payment day. We will notify you in writing if your monthly payment day is being changed to the 3rd of the month due to this provision.

(5) After April 30, 1997, all individuals who become entitled on one record and later entitled on another record, without a break in entitlement, will be paid all benefits to which they are entitled no later than their current payment day. Individuals who are being paid benefits on one record on the 3rd of the month, and who become entitled on another record without a break in entitlement, will continue to receive all benefits on the 3rd of the month.

(6) If the day regularly scheduled for the delivery of your benefit payment falls on a Saturday, Sunday, or Federal legal holiday, you will be paid on the first preceding day that is not a Saturday, Sunday, or Federal legal holiday.

[62 FR 6120, Feb. 11, 1997]

§ 404.1810 Expediting benefit payments.

(a) *General.* We have established special procedures to expedite the payment of benefits in certain initial and subsequent claims. This section tells how you may request an expedited payment and when we will be able to hasten your payments by means of this process.

(b) *Applicability of section.* (1) This section applies to monthly benefits payable under title II of the Act, except as indicated in paragraph (b)(2) of this section; and to those cases where we certify information to the Railroad Retirement Board.

(2) This section does not apply—

(i) If an initial determination has been made and a request for a reconsideration, a hearing, a review by the Appeals Council, or review by a Federal court is pending on any issue of entitlement to or payment of a benefit;

(ii) To any benefit for which a check has been cashed; or

(iii) To any benefit based on an alleged disability.

(c) *Request for payment.* (1) You shall submit to us a written request for payment of benefits in accordance with paragraph (c)(2) or (c)(3) of this section. Paragraph (c)(2) of this section applies if you were receiving payments regularly and you then fail to receive payment for one or more months. Paragraph (c)(3) of this section applies if we have not made a determination about your entitlement to benefits, or if we have suspended or withheld payment due, for example, to excess earnings or recovery of an overpayment.

(2) If you received a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 30 days after the 15th day of the month in which the payment was allegedly due. If you request is made before the end of the 30-day period, we will consider it to have been made at the end of the period.

(3)(i) If you did not receive a regular monthly benefit in the month before the month in which a payment was allegedly due, you may make a written request for payment any time 90 days after the later of—

(A) The date on which the benefit is alleged to have been due; or

(B) The date on which you furnished us the last information we requested from you.

(ii) If your request is made before the end of the 90-day period we will consider it to have been made at the end of the period.

(d) *Certification for payment.* If we find that benefits are due, we shall certify the benefits for payment in sufficient time to permit the payment to be made within 15 days after the request for expedited payment is made, or considered to have been made, as provided in paragraph (c) of this section.

(e) *Preliminary certification for payment.* If we determine that there is evidence, although additional evidence may be required for a final decision, that a monthly benefit due to you in a particular month was not paid, we may make preliminary certification of payment even though the 30-day or 90-day periods described in paragraph (c) of this section have not elapsed.

§ 404.1815 Withholding certification or payments.

(a) *When certification may be withheld.* After a determination or decision, we may withhold certification to the Managing Trustee, or, if we have already made certification, we may notify the Managing Trustee to withhold payments. We may do this if a question about the validity of the payment or payments to be made under the determination or decision arises as the result of one of the following events:

(1) A reconsideration (whether at the request of a claimant or on our own motion), hearing, or review is being conducted, or a civil action has been filed in a Federal district court concerning the determination or decision.

(2) An application or request is pending concerning the payment of benefits or a lump sum to another person, and the application or request is inconsistent, in whole or in part, with the payment or payments under the determination or decision.

(b) *When certification will not be withheld.* We will not withhold certification or payment as explained in paragraph (a) of this section unless evidence is submitted with the request or application that is sufficient to raise a reasonable question about the validity of the payment or payments under the determination or decision. We will not withhold certification of any amount of the payment or payments not in question. Your acceptance of any payment or payments will not affect your right to reconsideration, hearing, or review about any additional payment or payments you may claim.

§ 404.1820 Transfer or assignment of payments.

(a) *General.* We shall not certify payment to—

(1) Any person designated as your assignee or transferee; or

(2) Any person claiming payment because of an execution, levy, attachment, garnishment, or other legal process, or because of any bankruptcy or insolvency proceeding against or affecting you.

(b) *Enforcement of a child support or alimony obligation.* If you have a legal obligation to provide child support or make alimony payments and legal process is issued to enforce this obligation, the provisions of paragraph (a) of this section do not apply.

§ 404.1825 Joint payments to a family.

(a) *Two or more beneficiaries in same family.* If an amount is payable under title II of the Act for any month to two or more persons who are members of the same family, we may certify any two or more of the individuals for joint payment of the total benefits payable to them for the month.

(b) *Joint payee dies before cashing a check.* (1) If a check has been issued for joint payment to an individual and spouse residing in the same household, and one of the joint payees dies before the check has been cashed, we may authorize the surviving payee to cash the check. We make the authorization by placing on the face of the check a stamped legend signed by an official of the Social Security Administration or the Treasury Disbursing Office redesignating the survivor as the payee of the check.

(2) If the uncashed check represents benefits for a month after the month of death, we will not authorize the surviving payee to cash the check unless the proceeds of the check are necessary to meet the ordinary and necessary living expenses of the surviving payee.

(c) *Adjustment or recovery of overpayment.* If a check representing payment of benefits to an individual and spouse residing in the same household is cashed by the surviving payee under the authorization in paragraph (b) of this section, and the amount of the check exceeds the amount to which the surviving payee is entitled, we shall make appropriate adjustment or recovery of the excess amount.

Subpart T—Totalization Agreements

AUTHORITY: Secs. 205(a), 233, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 433, and 902(a)(5)).

SOURCE: 44 FR 42964, July 23, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 404.1901 Introduction.

(a) Under section 233 of the Social Security Act, the President may enter into an agreement establishing a totalization arrangement between the social security system of the United States and the social security system of a foreign country. An agreement permits entitlement to and the amount of old-age, survivors, disability, or derivative benefits to be based on a combination of a person's periods of coverage under the social security system of the United States and the social security system of the foreign country. An agreement also provides for the precluding of dual coverage and dual social security taxation for work covered under both systems. An agreement may provide that the provisions of the social security system of each country will apply equally to the nationals of both countries (regardless of where they reside). For this purpose, refugees, stateless persons, and other nonnationals who derive benefit rights from nationals, refugees, or stateless persons may be treated as nationals if they reside within one of the countries.

(b) The regulations in this subpart provide definitions and principles for the negotiation and administration of totalization agreements. Where necessary to accomplish the purposes of totalization, we will apply these definitions and principles, as appropriate and within the limits of the law, to accommodate the widely diverse characteristics of foreign social security systems.

§ 404.1902 Definitions.

For purposes of this subpart—

Act means the Social Security Act (42 U.S.C. 301 *et seq.*).

Agency means the agency responsible for the specific administration of a social security system including responsibility for implementing an agreement; the Social Security Administration (SSA) is the *agency* in the U.S.

Agreement means the agreement negotiated to provide coordination between the social security systems of the countries party to the agreement. The term agreement includes any administrative agreements concluded for purposes of administering the agreement.

Competent authority means the official with overall responsibility for administration of a country's social security system including applicable laws and international social security agreements; the Commissioner of Social Security is the *competent authority* in the U.S.

Period of coverage means a period of payment of contributions or a period of earnings based on wages for employment or on self-employment income, or any similar period recognized as equivalent under the social security system of the U.S. or under the social security system of the foreign country which is a party to an agreement.

Residence or *ordinarily resides*, when used in agreements, has the following meaning for the U.S. *Residence* or *ordinarily resides* in a country means that a person has established a home in that country intending to remain there permanently or for an indefinite period of time. Generally, a person will be considered to have established a home in a country if that person assumes certain economic burdens, such as the purchase of a dwelling or establishment of a business, and participates in the social and cultural activities of the community. If residence in a country is established, it may continue even though the person is temporarily absent from that country. Generally, an absence of six months or less will be considered temporary. If an absence is for more than six months, residence in the country will generally be considered to continue only if there is sufficient evidence to establish that the person intends to maintain the residence. Sufficient evidence would include the maintenance of a home or apartment in that country, the departure from the country with a reentry permit, or similar acts. The existence of business or family associations sufficient to warrant

the person's return would also be considered.

Social security system means a social insurance or pension system which is of general application and which provides for paying periodic benefits, or the actuarial equivalent, because of old-age, death, or disability.

[44 FR 42964, July 23, 1979, as amended at 62 FR 38452, July 18, 1997]

§404.1903 Negotiating totalization agreements.

An agreement shall be negotiated with the national government of the foreign country for the entire country. However, agreements may only be negotiated with foreign countries that have a social security system of general application in effect. The system shall be considered to be in effect if it is collecting social security taxes or paying social security benefits.

§404.1904 Effective date of a totalization agreement.

Section 233 of the Social Security Act provides that a totalization agreement shall become effective on any date provided in the agreement if—

(a) The date occurs after the expiration of a period during which at least one House of Congress has been in session on each of 60 days following the date on which the agreement is transmitted to Congress by the President; and

(b) Neither House of Congress adopts a resolution of disapproval of the agreement within the 60-day period described in paragraph (a) of this section.

[49 FR 29775, July 24, 1984]

§404.1905 Termination of agreements.

Each agreement shall contain provisions for its possible termination. If an agreement is terminated, entitlement to benefits and coverage acquired by an individual before termination shall be retained. The agreement shall provide for notification of termination to the other party and the effective date of termination.

BENEFIT PROVISIONS

§404.1908 Crediting foreign periods of coverage.

(a) *General.* To have foreign periods of coverage combined with U.S. periods of coverage for purposes of determining entitlement to and the amount of benefits payable under title II, an individual must have at least 6 quarters of coverage, as defined in section 213 of the Social Security Act, under the U.S. system. As a rule, SSA will accept foreign coverage information, as certified by the foreign country's agency, unless otherwise specified by the agreement. No credit will be given, however, for periods of coverage acquired before January 1, 1937.

(b) *For quarters of coverage purposes.* (1) Generally, a quarter of coverage (QC) will be credited for every 3 months (or equivalent period), or remaining fraction of 3 months, of coverage in a reporting period certified to SSA by the other country's agency. A reporting period used by a foreign country may be one calendar year or some other period of time. QCs based on foreign periods of coverage may be credited as QCs only to calender quarters not already QCs under title II. The QCs will be assigned chronologically beginning with the first calendar quarter (not already a QC under title II) within the reporting period and continuing until all the QCs are assigned, or the reporting period ends. Example: Country XYZ, which has an annual reporting period, certifies to SSA that a worker has 8 months of coverage in 1975, from January 1 to August 25. The worker has no QCs under title II in that year. Since 8 months divided by 3 months equals 2 QCs with a remainder of 2 months, the U.S. will credit the worker with 3 QCs. The QCs will be credited to the first 3 calendar quarters in 1975.

(2) If an individual fails to meet the requirements for currently insured status or the insured status needed for establishing a period of disability solely because of the assignment of QCs based on foreign coverage to calendar quarters chronologically, the QCs based on foreign coverage may be assigned to

different calendar quarters within the beginning and ending dates of the reporting period certified by the foreign country, but only as permitted under paragraph (b)(1) of this section.

§ 404.1910 Person qualifies under more than one totalization agreement.

(a) An agreement may not provide for combining periods of coverage under more than two social security systems.

(b) If a person qualifies under more than one agreement, the person will receive benefits from the U.S. only under the agreement affording the most favorable treatment.

(c) In the absence of evidence to the contrary, the agreement that affords the most favorable treatment for purposes of paragraph (b) of this section will be determined as follows:

(1) If benefit amounts are the same under all such agreements, benefits will be paid only under the agreement which affords the earliest month of entitlement.

(2) If benefit amounts and the month of entitlement are the same under all such agreements, benefits will be paid only under the agreement under which all information necessary to pay such benefits is first available.

(3) If benefit amounts under all such agreements are not the same, benefits will be paid only under the agreement under which the highest benefit is payable. However, benefits may be paid under an agreement under which a lower benefit is payable for months prior to the month of first entitlement to such higher benefit.

[44 FR 42964, July 23, 1979, as amended at 49 FR 29775, July 24, 1984]

§ 404.1911 Effects of a totalization agreement on entitlement to hospital insurance benefits.

A person may not become entitled to hospital insurance benefits under section 226 or section 226A of the Act by combining the person's periods of coverage under the social security system of the United States with the person's periods of coverage under the social security system of the foreign country. Entitlement to hospital insurance benefits is not precluded if the person otherwise meets the requirements.

COVERAGE PROVISIONS

§ 404.1913 Precluding dual coverage.

(a) *General.* Employment or self-employment or services recognized as equivalent under the Act or the social security system of the foreign country shall, on or after the effective date of the agreement, result in a period of coverage under the U.S. system or under the foreign system, but not under both. Methods shall be set forth in the agreement for determining under which system the employment, self-employment, or other service shall result in a period of coverage.

(b) *Principles for precluding dual coverage.* (1) An agreement precludes dual coverage by assigning responsibility for coverage to the U.S. or a foreign country. An agreement may modify the coverage provisions of title II of the Act to accomplish this purpose. Where an agreement assigns coverage to the foreign country, it may exempt from coverage services otherwise covered by the Act. Where an agreement assigns coverage to the U.S., it may extend coverage to services not otherwise covered by the Act but only for taxable years beginning on or after April 20, 1983.

(2) If the work would otherwise be covered by both countries, an agreement will exempt it from coverage by one of the countries.

(3) Generally, an agreement will provide that a worker will be covered by the country in which he or she is employed and will be exempt from coverage by the other country.

Example: A U.S. national employed in XYZ country by an employer located in the United States will be covered by XYZ country and exempt from U.S. coverage.

(4) An agreement may provide exceptions to the principle stated in paragraph (b)(3) of this section so that a worker will be covered by the country to which he or she has the greater attachment.

Example: A U.S. national sent by his employer located in the United States to work temporarily for that employer in XYZ country will be covered by the United States and will be exempt from coverage by XYZ country.

(5) Generally, if a national of either country resides in one country and has self employment income that is covered by both countries, an agreement will provide that the person will be covered by the country in which he or she resides and will be exempt from coverage by the other country.

(6) Agreements may provide for variations from the general principles for precluding dual coverage to avoid inequitable or anomalous coverage situations for certain workers. However, in all cases coverage must be provided by one of the countries.

[44 FR 42964, July 23, 1979, as amended at 50 FR 36575, Sept. 9, 1985]

§404.1914 Certificate of coverage.

Under some agreements, proof of coverage under one social security system may be required before the individual may be exempt from coverage under the other system. Requests for certificates of coverage under the U.S. system may be submitted by the employer, employee, or self-employed individual to SSA.

§404.1915 Payment of contributions.

On or after the effective date of the agreement, to the extent that employment or self-employment (or service recognized as equivalent) under the U.S. social security system or foreign system is covered under the agreement, the agreement shall provide that the work or equivalent service be subject to payment of contributions or taxes under only one system (see sections 1401(c), 3101(c), and 3111(c) of the Internal Revenue Code of 1954). The system under which contributions or taxes are to be paid is the system under which there is coverage pursuant to the agreement.

COMPUTATION PROVISIONS

§404.1918 How benefits are computed.

(a) *General.* Unless otherwise provided in an agreement, benefits will be computed in accordance with this section. Benefits payable under an agreement are based on a pro rata primary insurance amount (PIA), which we determine as follows:

(1) We establish a theoretical earnings record for a worker which attributes to all computation base years (see §§404.211(b) and 404.241(c)) the same relative earnings position (REP) as he or she has in the years of his or her actual U.S. covered work. As explained in paragraph (b)(3) of this section, the REP is derived by determining the ratio of the worker's actual U.S. covered earnings in each year to the average of the total U.S. covered wages of all workers for that year, and then averaging the ratios for all such years. This average is the REP and is expressed as a percentage.

(2) We compute a theoretical PIA as prescribed in §404.1918(c) based on the theoretical earnings record and the provisions of subpart C of this part.

(3) We multiply the theoretical PIA by a fraction equal to the number of quarters of coverage (QC's) which the worker completed under the U.S. Social Security system over the number of calendar quarters in the worker's coverage lifetime (see paragraph (d)(2) of this section). See §404.140 for the definition of QC.

(4) If the pro rata PIA is higher than the PIA which would be computed if the worker were insured under the U.S. system without totalization, the pro rata PIA will be reduced to the later PIA.

(b) *Establishing a theoretical earnings record.* (1) To establish a worker's theoretical earnings record, we divide his or her U.S. earnings in each year credited with at least one U.S. QC by the average of the total wages of all workers for that year and express the quotient as a percentage. For the years 1937 through 1950, the average of the total wages is as follows:

Year	Average of the total wages of all workers
1937	$1,137.96
1938	1,053.24
1939	1,142.36
1940	1,195.00
1941	1,276.04
1942	1,454.28
1943	1,713.52
1944	1,936.32
1945	2,021.40
1946	1,891.76
1947	2,175.32
1948	2,361.64
1949	2,483.20
1950	2,543.96

(2) For years after 1950, the average of the total wages is as prescribed in § 404.211(c). If a worker has earnings in the year preceding the year of eligibility or death, or in a later year, we may not have been able to establish the average of the total wages of all workers for that year. Therefore, we will divide a worker's actual earnings in these years by the average of the total wages for the latest year for which that information is available. Average wage information is considered available on January 1 of the year following the year in which it is published in the FEDERAL REGISTER.

(3) The percentages for all years of actual covered earnings are then averaged to give the worker's REP for the entire period of work in the U.S. In determining the percentages for all years of covered earnings and the REP, we make adjustments as necessary to take account of the fact that the covered earnings for some years may have involved less than four U.S. QC's. The actual earnings that are taken into account in determining the percentage for any year with 1, 2, or 3 QC's cannot exceed ¼, ½, or ¾, respectively, of the maximum creditable earnings for that year. When we determine the REP from the percentages for all years, we add the percentages for all years, divide this sum by the total number of QC's credited to the worker, and multiply this quotient by 4 (see Example 1 of paragraph (d) of this section). This has the effect of calculating the REP on a quarterly basis.

(4) For each of the worker's computation base years (see §§ 404.211(b), 404.221(b) and 404.241(c)), we multiply the average of the total wages of all workers for that year by the worker's REP. The product is the amount of earnings attributed to the worker for that year, subject to the annual wage limitation (see § 404.1047). The worker's theoretical earnings record consists of his or her attributed earnings based on his or her REP for all computation base years. However, we do not attribute earnings to computation base years before the year of attainment of age 22 or to computation base years beginning with the year of attainment of retirement age (or the year in which a period of disability begins), unless the worker is actually credited with U.S. earnings in those years. In death cases, earnings for the year of death will be attributed only through the quarter of death, on a proportional basis.

(c) *Determining the theoretical PIA.* We determine the worker's theoretical PIA based on his or her theoretical earnings record by applying the same computation method that would have applied under subpart C if the worker had these theoretical earnings and had qualified for benefits without application of an agreement. However, when the criteria in § 404.210(a) for the Average Indexed Monthly Earnings (AIME) computation method are met, only that method is used. If these criteria are not met but the criteria in § 404.220(a) for the Average Monthly Wage method are met, then only that method is used. If neither of these criteria are met, then the old-start method described in § 404.241 is used. If a theoretical PIA is to be determined based on a worker's AIME, theoretical earnings amounts for each year, determined under paragraph (b) of this section, are indexed in determining the AIME under § 404.211.

(d) *Determining the pro rata PIA.* We then determine a pro rata PIA from the theoretical PIA. The pro rata PIA is the product of—

(1) The theoretical PIA; and

(2) The ratio of the worker's actual number of U.S. QC's to the number of calendar quarters in the worker's coverage lifetime. A coverage lifetime means the worker's benefit computation years as determined under § 404.211(e), § 404.221(c), or § 404.241(d).

Example 1: C attains age 62 in 1982 and needs 31 QC's to be insured. C worked under the U.S. system from July 1, 1974 to December 31, 1980 and therefore has only 6½ years during which he worked under the U.S. system (26 QC's). C, however, has worked under the Social Security system of a foreign country that is party to a totalization agreement, and his total U.S. and foreign work, combined as described in § 404.1908, equals more than 31 QC's. Thus, the combined coverage gives C insured status. The benefit is computed as follows:

Step 1: Establish C's theoretical earnings record:

The following table shows: (1) C's actual U.S. covered earnings for each year, (2) the average of the total wages of all workers for that year and (3) the ratio of (1) to (2):

Year	QC's	C's actual U.S. covered earnings	National average wage	Percentage ratio of (1) to (2)
		(1)	(2)	(3)
1974	2	$2,045.08	$8,030.76	25.46558
1975	4	7,542.00	8,630.92	87.38350
1976	4	9,016.00	9,226.48	97.71874
1977	4	9,952.00	9,779.44	101.76452
1978	4	10,924.00	10,556.03	103.48587
1979	4	12,851.00	11,479.46	111.94777
1980	4	11,924.00	12,513.46	95.28939

C's REP is the average of the ratios in column 3, adjusted to take account of the fact that C had only 2 QC's in 1974. Thus, the REP equals the sum of the figures in column 3 (623.05537), divided by the total number of C's QC's (26) and multiplied by 4, or 95.85467 percent.

Since C attained age 62 in 1982, his computation base years are 1951 through 1981. To establish his theoretical earnings record we use 95.85467 percent of the national average wage for each of the years 1951 through 1981. Since national average wage data is not available for 1981, for that year we attribute 95.85467 percent of the national average wage for 1980 or $11,994.74. His theoretical earnings record would look like this:

1951	$2,683.13
1952	2,850.07
1953	3,009.30
1954	3,024.83
1955	3,164.58
1956	3,385.93
1957	3,490.76
1958	3,521.51
1959	3,695.96
1960	3,841.01
1961	3,917.35
1962	4,113.51
1963	4,214.38
1964	4,386.62
1965	4,465.60
1966	4,733.65
1967	4,997.33
1968	5,340.79
1969	5,649.44
1970	5,929.80
1971	6,227.75
1972	6,838.08
1973	7,265.94
1974	7,697.86
1975	8,273.14
1976	8,844.01
1977	9,374.05
1978	10,118.45
1979	11,003.60
1980	11,994.74
1981	11,994.74

Step 2: Compute the theoretical PIA: Since C attains age 62 in 1982, we determine his theoretical PIA using an AIME computation. In applying the AIME computation, we index each year's earnings on the theoretical earnings record in accordance with §404.211(d). In this example, the theoretical PIA is $453.

Step 3: Compute the pro rata PIA:

$$\frac{\text{Theoretical PIA} - \text{Actual U.S. QC's}}{\text{calendar quarters in benefit computation years}}$$

$$\frac{\$453 - 26 \text{ QC's } (6\tfrac{1}{2} \text{ years})}{104 \text{ quarters } (26 \text{ years})}$$

$$= \$113.20 \text{ pro rata PIA}$$

Example 2: M needs 27 QC's to be insured, but she has only 3 years of work (12 QC's) under the U.S. system. M has enough foreign work, however, to be insured. She attained age 62 in 1978, and her U.S. covered earnings were in 1947, 1948 and 1949. Based on M's date of birth, her theoretical PIA can be computed, in accordance with §404.220, under a new start method. If M's earnings in 1947, 1948, and 1949 were 50 percent, 60 percent and 70 percent, respectively, of the average wage for each year, her REP would be 60 percent. For each year in the computation period, 60 percent of the average wage for that year will be attributed as M's assumed earnings. The theoretical PIA will then be computed as described in §§404.220 through 404.222.

To determine M's pro rata PIA, the theoretical PIA will be multiplied by the ratio of the actual number of U.S. QC's to the number of calendar quarters in the benefit computation years. There are 22 benefit computation years, or 88 quarters. The pro rata PIA would, therefore, be $\frac{12}{88} \times$ theoretical PIA.

(e) *Rounding of benefits.* (1) If the effective date of the pro rata PIA is before June 1982, we will round to the next higher multiple of 10 cents if it is not already a multiple of 10 cents.

(2) If the effective date of the pro rata PIA is June 1982 or later, we will round to the next lower multiple of 10 cents if it is not already a multiple of 10 cents.

(f) *Auxiliary and survivors benefits; reductions; family maximum.* We will determine auxiliary and survivors benefit amounts (see subpart D) on the basis of the pro rata PIA. We will apply the regular reductions for age under section 202(q) of the Act to the benefits of the worker or to any auxiliaries or survivors which are based on the pro rata PIA (see §404.410). Benefits will be payable subject to the family maximum (see §404.403) derived from the pro rata PIA. If the pro rata PIA is less than the

minimum PIA, the family maximum will be 1½ times the pro rata PIA.

[49 FR 29775, July 24, 1984]

§ 404.1919 How benefits are recomputed.

Unless otherwise provided in an agreement, we will recompute benefits in accordance with this section. We will recompute the pro rata PIA only if the inclusion of the additional earnings results in an increase in the benefits payable by the U.S. to all persons receiving benefits on the basis of the worker's earnings. Subject to this limitation, the pro rata PIA will be automatically recomputed (see § 404.285) to include additional earnings under the U.S. system. In so doing, a new REP will be established for the worker, taking the additional earnings into account, and assumed earnings in the computation base years used in the original computation will be refigured using the new REP. Assumed earnings will also be determined for the year of additional earnings using the new REP. The additional U.S. earnings will also be used in refiguring the ratio described in § 404.1918(d)(2).

[49 FR 29777, July 24, 1984]

§ 404.1920 Supplementing the U.S. benefit if the total amount of the combined benefits is less than the U.S. minimum benefit.

If a resident of the U.S. receives benefits under an agreement from both the U.S. and from the foreign country, the total amount of the two benefits may be less than the amount for which the resident would qualify under the U.S. system based on the minimum PIA as in effect for persons first becoming eligible for benefits before January 1982. An agreement may provide that in the case of an individual who first becomes eligible for benefits before January 1982, the U.S. will supplement the total amount to raise it to the amount for which the resident would have qualified under the U.S. system based on the minimum PIA. (The minimum benefit will be based on the first figure in column IV in the table in section 215(a) of the Act for a person becoming eligible for the benefit before January 1, 1979, or the PIA determined under section 215(a)(1)(C)(i)(I) of the Act (as in effect in December 1981) for a person becoming eligible for the benefit after December 31, 1978.)

[49 FR 29777, July 24, 1984]

§ 404.1921 Benefits of less than $1 due.

If the monthly benefit amount due an individual (or several individuals, e.g., children, where several benefits are combined in one check) as a result of a claim filed under an agreement is less than $1, the benefits may be accumulated until they equal or exceed $5.

OTHER PROVISIONS

§ 404.1925 Applications.

(a)(1) An application, or written statement requesting benefits, filed with the competent authority or agency of a country with which the U.S. has concluded an agreement shall be considered an application for benefits under title II of the Act as of the date it is filed with the competent authority or agency if—

(i) An applicant expresses or implies an intent to claim benefits from the U.S. under an agreement; and

(ii) The applicant files an application that meets the requirements in subpart G of this part.

(2) The application described in paragraph (a)(1)(ii) of this section must be filed, even if it is not specifically provided for in the agreement.

(b) Benefits under an agreement may not be paid on the basis of an application filed before the effective date of the agreement.

§ 404.1926 Evidence.

(a) An applicant for benefits under an agreement shall submit the evidence needed to establish entitlement, as provided in subpart H of this part. Special evidence requirements for disability benefits are in subpart P of this part.

(b) Evidence submitted to the competent authority or agency of a country with which the U.S. has concluded an agreement shall be considered as evidence submitted to SSA. SSA shall use the rules in §§ 404.708 and 404.709 to determine if the evidence submitted is sufficient, or if additional evidence is needed to prove initial or continuing entitlement to benefits.

(c) If an application is filed for disability benefits, SSA shall consider medical evidence submitted to a competent authority or agency, as described in paragraph (b) of this section, and use the rules of subpart P of this part for making a disability determination.

§ 404.1927 Appeals.

(a) A request for reconsideration, hearing, or Appeals Council review of a determination that is filed with the competent authority or agency of a country with which the U.S. has concluded an agreement, shall be considered to have been timely filed with SSA if it is filed within the 60-day time period provided in §§ 404.911, 404.918, and 404.946.

(b) A request for reconsideration, hearing, or Appeals Council review of a determination made by SSA resulting from a claim filed under an agreement shall be subject to the provisions in subpart J of this part. The rules governing administrative finality in subpart J of this part shall also apply.

§ 404.1928 Effect of the alien non-payment provision.

An agreement may provide that a person entitled to benefits under title II of the Social Security Act may receive those benefits while residing in the foreign country party to the agreement, regardless of the alien non-payment provision (see § 404.460).

§ 404.1929 Overpayments.

An agreement may not authorize the adjustment of title II benefits to recover an overpayment made under the social security system of a foreign country (see § 404.501). Where an overpayment is made under the U.S. system, the provisions in subpart F of this part will apply.

§ 404.1930 Disclosure of information.

The use of information furnished under an agreement generally shall be governed by the national statutes on confidentiality and disclosure of information of the country that has been furnished the information. (The U.S. will be governed by pertinent provisions of the Social Security Act, the Freedom of Information Act, the Privacy Act, the Tax Reform Act, and other related statutes.) In negotiating an agreement, consideration, should be given to the compatibility of the other country's laws on confidentiality and disclosure to those of the U.S. To the extent possible, information exchanged between the U.S. and the foreign country should be used exclusively for purposes of implementing the agreement and the laws to which the agreement pertains.

Subpart U—Representative Payment

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

SOURCE: 47 FR 30472, July 14, 1982, unless otherwise noted.

§ 404.2001 Introduction.

(a) *Explanation of representative payment.* This subpart explains the principles and procedures that we follow in determining whether to make representative payment and in selecting a representative payee. It also explains the responsibilities that a representative payee has concerning the use of the funds he or she receives on behalf of a beneficiary. A representative payee may be either a person or an organization selected by us to receive benefits on behalf of a beneficiary. A representative payee will be selected if we believe that the interest of a beneficiary will be served by representative payment rather than direct payment of benefits. Generally, we appoint a representative payee if we have determined that the beneficiary is not able to manage or direct the management of benefit payments in his or her interest.

(b) *Policy used to determine whether to make representative payment.* (1) Our policy is that every beneficiary has the right to manage his or her own benefits. However, some beneficiaries due to a mental or physical condition or due to their youth may be unable to do so. Under these circumstances, we may determine that the interests of the beneficiary would be better served if we certified benefit payments to another person as a representative payee.

(2) If we determine that representative payment is in the interest of a

beneficiary, we will appoint a representative payee. We may appoint a representative payee even if the beneficiary is a legally competent individual. If the beneficiary is a legally incompetent individual, we may appoint the legal guardian or some other person as a representative payee.

(3) If payment is being made directly to a beneficiary and a question arises concerning his or her ability to manage or direct the management of benefit payments, we will, if the beneficiary is 18 years old or older and has not been adjudged legally incompetent, continue to pay the beneficiary until we make a determination about his or her ability to manage or direct the management of benefit payments and the selection of a representative payee.

§ 404.2010 When payment will be made to 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.

(b) Generally, if a beneficiary is under age 18, we will pay benefits to a representative payee. However, in certain situations, we will make direct payments to a beneficiary under age 18 who shows the ability to manage the benefits. For example, we make direct payments to a beneficiary under age 18 if the beneficiary is—

(1) Receiving disability insurance benefits on his or her own Social Security earnings record; or

(2) Serving in the military services; or

(3) Living alone and supporting himself or herself; or

(4) A parent and files for himself or herself and/or his or her child and he or she has experience in handling his or her own finances; or

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

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

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2015 Information considered in determining whether to make representative payments.

In determining whether to make representative payment we consider the following information:

(a) *Court determinations.* If we learn that a beneficiary has been found to be legally incompetent, a certified copy of the court's determination will be the basis of our determination to make representative payment.

(b) *Medical evidence.* When available, we will use medical evidence to determine if a beneficiary is capable of managing or directing the management of benefit payments. For example, a statement by a physician or other medical professional based upon his or her recent examination of the beneficiary and his or her knowledge of the beneficiary's present condition will be used in our determination, if it includes information concerning the nature of the beneficiary's illness, the beneficiary's chances for recovery and the opinion of the physician or other medical professional as to whether the beneficiary is able to manage or direct the management of benefit payments.

(c) *Other evidence.* We will also consider any statements of relatives, friends and other people in a position to know and observe the beneficiary, which contain information helpful to us in deciding whether the beneficiary is able to manage or direct the management of benefit payments.

§ 404.2020 Information considered in selecting a representative payee.

In selecting a payee we try to select the person, agency, organization or institution that will best serve the interest of the beneficiary. In making our selection we consider—

(a) The relationship of the person to the beneficiary;

(b) The amount of interest that the person shows in the beneficiary;

(c) Any legal authority the person, agency, organization or institution has to act on behalf of the beneficiary;

(d) Whether the potential payee has custody of the beneficiary; and

(e) Whether the potential payee is in a position to know of and look after the needs of the beneficiary.

§ 404.2021 Order of preference in selecting a representative payee.

As a guide in selecting a representative payee, categories of preferred payees have been established. These preferences are flexible. Our primary concern is to select the payee who will best serve the beneficiary's interest. The preferences are:

(a) For beneficiaries 18 years old or older, our preference is—

(1) A legal guardian, spouse (or other relative) who has custody of the beneficiary or who demonstrates strong concern for the personal welfare of the beneficiary;

(2) A friend who has custody of the beneficiary or demonstrates strong concern for the personal welfare of the beneficiary;

(3) A public or nonprofit agency or institution having custody of the beneficiary;

(4) A private institution operated for profit and licensed under State law, which has custody of the beneficiary; and

(5) Persons other than above who are qualified to carry out the responsibilities of a payee and who are able and willing to serve as a payee for a beneficiary; e.g., members of community groups or organizations who volunteer to serve as payee for a beneficiary.

(b) For beneficiaries under age 18, our preference is—

(1) A natural or adoptive parent who has custody of the beneficiary, or a guardian;

(2) A natural or adoptive parent who does not have custody of the beneficiary, but is contributing toward the beneficiary's support and is demonstrating strong concern for the beneficiary's well being;

(3) A natural or adoptive parent who does not have custody of the beneficiary and is not contributing toward his or her support but is demonstrating strong concern for the beneficiary's well being;

(4) A relative or stepparent who has custody of the beneficiary;

(5) A relative who does not have custody of the beneficiary but is contributing toward the beneficiary's support and is demonstrating concern for the beneficiary's well being;

(6) A relative or close friend who does not have custody of the beneficiary but is demonstrating concern for the beneficiary's well being; and

(7) An authorized social agency or custodial institution.

[47 FR 30472, July 14, 1982; 47 FR 32936, July 30, 1982]

§ 404.2025 Information to be submitted by a representative payee.

(a) Before we select a representative payee, the payee applicant must give us information showing his or her relationship to the beneficiary and his or her responsibility for the care of the beneficiary.

(b) Anytime after we have selected a payee, we may ask the payee to give us information showing a continuing relationship to the beneficiary and a continuing responsibility for the care of the beneficiary. If the payee does not give us the requested information within a reasonable period of time, we may stop paying the payee unless we determine that the payee had a good reason for not complying with our request, and we receive the information requested.

§ 404.2030 Advance notice of the determination to make representative payment.

(a) Generally, whenever we intend to make representative payment and to name a payee, we notify the beneficiary or the individual acting on his or her behalf, of our proposed actions. In this notice we tell the person that we plan to name a representative payee and who that payee will be. We also ask the person to contact us if he or she objects to either proposed action. If he or she objects to either proposed action, the person may—

(1) Review the evidence upon which the proposed actions will be based; and

(2) Submit any additional evidence regarding the proposed actions.

(b) If the person objects to the proposed actions, we will review our proposed determinations and consider any additional information given to us. We

will then issue our determinations. If the person is dissatisfied with either determination, he or she may request a reconsideration.

(c) If the person does not object to the proposed actions, we will issue our determinations. If the person is dissatisfied with either determination, he or she may request a reconsideration.

[47 FR 30472, July 14, 1982; 47 FR 32936, July 30, 1982]

§ 404.2035 Responsibilities of a representative payee.

A representative payee has a responsibility to—

(a) Use the payments he or she receives only for the use and benefit of the beneficiary in a manner and for the purposes he or she determines, under the guidelines in this subpart, to be in the best interests of the beneficiary;

(b) Notify us of any event that will affect the amount of benefits the beneficiary receives or the right of the beneficiary to receive benefits;

(c) Submit to us, upon our request, a written report accounting for the benefits received; and

(d) Notify us of any change in his or her circumstances that would affect performance of the payee responsibilities.

§ 404.2040 Use of benefit payments.

(a) *Current maintenance.* (1) We will consider that payments we certify to a representative payee have been used for the use and benefit of the beneficiary if they are used for the beneficiary's current maintenance. Current maintenance includes cost incurred in obtaining food, shelter, clothing, medical care, and personal comfort items.

Example: An aged beneficiary is entitled to a monthly Social Security benefit of $400. Her son, who is her payee, disburses her benefits in the following manner:

Rent and utilities	$200
Medical	25
Food	60
Clothing (coat)	55
Savings	30
Miscellaneous	30

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

(2) Notwithstanding the provisions of paragraph (a)(1) of this section, if a beneficiary is a member of an Aid to Families With Dependent Children (AFDC) assistance unit, we do not consider it inappropriate for a representative payee to make the benefit payments available to the AFDC assistance unit.

(b) *Institutional care.* If a beneficiary is receiving care in a Federal, State, or private institution because of mental or physical incapacity, current maintenance includes the customary charges made by the institution, as well as expenditures for those items which will aid in the beneficiary's recovery or release from the institution or expenses for personal needs which will improve the beneficiary's conditions while in the institution.

Example: An institutionalized beneficiary is entitled to a monthly Social Security benefit of $320. The institution charges $700 a month for room and board. The beneficiary's brother, who is the payee, learns the beneficiary needs new shoes and does not have any funds to purchase miscellaneous items at the institution's canteen.

The payee takes his brother to town and buys him a pair of shoes for $29. He also takes the beneficiary to see a movie which costs $3. When they return to the institution, the payee gives his brother $3 to be used at the canteen.

Although the payee normally withholds only $25 a month from Social Security benefit for the beneficiary's personal needs, this month the payee deducted the above expenditures and paid the institution $10 less than he usually pays.

The above expenditures represent what we would consider to be proper expenditures for current maintenance.

(c) *Support of legal dependents.* If the current maintenance needs of the beneficiary are met, the payee may use part of the payments for the support of the beneficiary's legally dependent spouse, child, and/or parent.

Example: A disabled beneficiary receives a Veterans Administration (VA) benefit of $325 and a Social Security benefit of $525. The beneficiary resides in a VA hospital and his VA benefits are sufficient to provide for all of his needs; i.e., cost of care and personal needs. The beneficiary's legal dependents—his wife and two children—have a total income of $250 per month in Social Security benefits. However, they have expenses of approximately $450 per month.

Because the VA benefits are sufficient to meet the beneficiary's needs, it would be appropriate to use part of his Social Security benefits to support his dependents.

(d) *Claims of creditors.* A payee may not be required to use benefit payments to satisfy a debt of the beneficiary, if the debt arose prior to the first month for which payments are certified to a payee. If the debt arose prior to this time, a payee may satisfy it only if the current and reasonably foreseeable needs of the beneficiary are met.

Example: A retroactive Social Security check in the amount of $1,640, representing benefits due for July 1980 through January 1981, was issued on behalf of the beneficiary to the beneficiary's aunt who is the representative payee. The check was certified in February 1981.

The nursing home, where the beneficiary resides, submitted a bill for $1,139 to the payee for maintenance expenses the beneficiary incurred during the period from June 1980 through November 1980. (Maintenance charges for December 1980 through February 1981 had previously been paid.)

Because the benefits were not required for the beneficiary's current maintenance, the payee had previously saved over $500 for the beneficiary and the beneficiary had no foreseeable needs which would require large disbursements, the expenditure for the maintenance charges would be consistent with our guidelines.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2040a Compensation for qualified organizations serving as representative payees.

(a) *General.* A community-based, nonprofit social service agency which meets the requirements set out in paragraph (b) of this section may request our authorization to collect a monthly fee from a beneficiary for providing representative payee services.

(b) *Organizations that may request compensation.* We will authorize an organization to collect a fee if all the following requirements are met.

(1) It is community-based, i.e., serves or represents one or more neighborhoods, city or county locales and is located within its service area.

(2) It is a nonprofit social service organization founded for religious, charitable or social welfare purposes and is tax exempt under section 501(c) of the Internal Revenue Code.

(3) It is bonded or licensed in the State in which it serves as representative payee.

(4) It regularly provides representative payee services concurrently to at least five beneficiaries. An organization which has received our authorization to collect a fee for representative payee services, but is temporarily not a payee for at least five beneficiaries, may request our approval to continue to collect fees.

(5) It was in existence on October 1, 1988.

(6) It is not a creditor of the beneficiary. See paragraph (c) of this section for exceptions to this requirement.

(c) *Creditor relationship.* If an organization has a creditor relationship with a beneficiary, we may, on a case-by-case basis, authorize the organization to collect a fee for payee services notwithstanding this relationship. To provide this authorization, we will review all of the evidence submitted by the organization and authorize collection of a fee when:

(1) The services provided by the organization help to meet the current needs of the beneficiary; and

(2) The amount the organization charges the beneficiary for these services is commensurate with the beneficiary's ability to pay.

(d) *Authorization process.* (1) An organization must request in writing and receive an authorization from us before it may collect a fee.

(2) An organization seeking authorization to collect a fee must also give us evidence to show that it is qualified, pursuant to paragraphs (b) and (c) of this section, to collect a fee.

(3) If the evidence provided to us by the organization shows that the requirements of this section are met, we will notify the organization in writing that it is authorized to collect a fee. If we need more evidence, or if we are not able to authorize the collection of a fee, we will also notify the organization in writing that we have not authorized the collection of a fee.

(e) *Revocation, cancellation and expiration of the authorization.* (1) We will revoke an authorization to collect a fee if we have evidence which establishes

that an organization no longer meets the requirements of this section. We will issue a written notice to the organization explaining the reason(s) for the revocation.

(2) An organization may cancel its authorization at any time upon written notice to us.

(f) *Notices.* The written notice we will send to an organization authorizing the collection of a fee will contain an effective date for the collection of a fee pursuant to paragraphs (b) and (c) of this section. The effective date will be no earlier than the month in which the organization asked for authorization to collect a fee. The notice will be applicable to all beneficiaries for whom the organization was payee at the time of our authorization and all beneficiaries for whom the organization becomes payee while the authorization is in effect.

(g) *Limitation on fees.* (1) An organization authorized to collect a fee pursuant to this section may collect from a beneficiary a monthly fee for expenses (including overhead) it has incurred in providing payee services to a beneficiary if the fee does not exceed the lesser of—

(i) 10 percent of the beneficiary's monthly benefit payments; or

(ii) $25.00 per month.

(2) Any agreement providing for a fee in excess of the amount permitted under paragraph (g)(1) of this section shall be void and treated as misuse of benefits by the organization of the individual's benefits under § 404.2041.

(3) A fee may be collected for any month during which the organization—

(i) Provides representative payee services;

(ii) Receives a benefit payment for the beneficiary; and

(iii) Is authorized to receive a fee for representative payee services.

(4) Fees for services may not be taken from any funds conserved for the beneficiary by a payee in accordance with § 404.2045.

(5) Generally, an organization may not collect a fee for months in which it does not receive a benefit payment. However, an organization will be allowed to collect a fee for months in which it did not receive a payment if we later issue payments for these months and the organization:

(i) Received our approval to collect a fee for the months for which payment is made;

(ii) Provided payee services in the months for which payment is made; and

(iii) Was the payee when the retroactive payment was paid by us.

(6) An authorized organization may not collect a fee for the expenses it incurred in providing representative payee services if these expenses are paid from another source.

[57 FR 23057, June 1, 1992]

§ 404.2041 Liability for misuse of benefit payments.

Our obligation to the beneficiary is completely discharged when we make a correct payment to a representative payee on behalf of the beneficiary. The payee in his or her personal capacity, and not SSA, may be liable if the payee misuses the beneficiary's benefits.

§ 404.2045 Conservation and investment of benefit payments.

(a) *General.* After the representative payee has used benefit payments consistent with the guidelines in this subpart (see § 404.2040 regarding use of benefits), any remaining amount shall be conserved or invested on behalf of the beneficiary. Conserved funds should be invested in accordance with the rules followed by trustees. Any investment must show clearly that the payee holds the property in trust for the beneficiary.

Example: A State institution for mentally retarded children, which is receiving Medicaid funds, is representative payee for several Social Security beneficiaries. The checks the payee receives are deposited into one account which shows that the benefits are held in trust for the beneficiaries. The institution has supporting records which show the share each individual has in the account. Funds from this account are disbursed fairly quickly after receipt for the current support and maintenance of the beneficiaries as well as for miscellaneous needs the beneficiaries may have. Several of the beneficiaries have significant accumulated resources in this account. For those beneficiaries whose benefits have accumulated over $150, the funds should be deposited in an

interest-bearing account or invested relatively free of risk on behalf of the beneficiaries.

(b) *Preferred investments.* Preferred investments for excess funds are U.S. Savings Bonds and deposits in an interest or dividend paying account in a bank, trust company, credit union, or savings and loan association which is insured under either Federal or State law. The account must be in a form which shows clearly that the representative payee has only a fiduciary and not a personal interest in the funds. If the payee is the legally appointed guardian or fiduciary of the beneficiary, the account may be established to indicate this relationship. If the payee is not the legally appointed guardian or fiduciary, the accounts may be established as follows:

(1) For U.S. Savings Bonds—

(Name of beneficiary) (Social Security Number), for whom (Name of payee) is representative payee for Social Security benefits;

(2) For interest or dividend paying accounts—

(Name of beneficiary) by (Name of payee), representative payee.

(c) *Interest and dividend payments.* The interest and dividends which result from an investment are the property of the beneficiary and may not be considered to be the property of the payee.

[47 FR 30472, July 14, 1982, as amended at 54 FR 35483, Aug. 28, 1989]

§ 404.2050 When a new representative payee will be selected.

When we learn that the interests of the beneficiary are not served by continuing payment to the present payee or that the present payee is no longer able to carry out the payee responsibilities, we try to find a new payee. We will select a new payee if we find a preferred payee or if the present payee—

(a) Has not used the benefit payments on the beneficiary's behalf in accordance with the guidelines in this subpart;

(b) Has not carried out the other responsibilities described in this subpart;

(c) Dies;

(d) No longer wishes to be payee;

(e) Is unable to manage the benefit payments; or

(f) Fails to cooperate, within a reasonable time, in providing evidence, accounting, or other information which we request.

§ 404.2055 When representative payment will be stopped.

If a beneficiary receiving representative payment shows us that he or she is mentally and physically able to manage or direct the management of benefit payments, we will make direct payment. Information which the beneficiary may give us to support his or her request for direct payment include the following—

(a) A physician's statement regarding the beneficiary's condition, or a statement by a medical officer of the institution where the beneficiary is or was confined, showing that the beneficiary is able to manage or direct the management of his or her funds; or

(b) A certified copy of a court order restoring the beneficiary's rights in a case where a beneficiary was adjudged legally incompetent; or

(c) Other evidence which establishes the beneficiary's ability to manage or direct the management of benefits.

§ 404.2060 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested benefit payments shall transfer these funds, and the interest earned from the invested funds, to either a successor payee or to us, as we will specify. If the funds and the earned interest are returned to us, we will recertify them to a successor representative payee or to the beneficiary.

[47 FR 30472, July 14, 1982; 47 FR 34781, Aug. 11, 1982]

§ 404.2065 Accounting for benefit payments.

A representative payee is accountable for the use of benefits. We may require periodic written reports from representative payees. We may also, in certain situations, verify how a representative payee used the funds. A representative payee should keep

records of what was done with the benefit payments in order to make accounting reports. We may ask the following questions—

(a) The amount of benefit payments on hand at the beginning of the accounting period;

(b) How the benefit payments were used;

(c) How much of the benefit payments were saved and how the savings were invested;

(d) Where the beneficiary lived during the accounting period; and

(e) The amount of the beneficiary's income from other sources during the accounting period. We ask for information about other funds to enable us to evaluate the use of benefit payments.

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 205(a), 222, and 702(a)(5) of the Social Security Act (42 U.S.C. 405(a), 422, and 902(a)(5)).

SOURCE: 48 FR 6293, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

§ 404.2101 General.

Section 222(d) of the Social Security Act authorizes the transfer from the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund of such sums as may be necessary to pay for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled individuals entitled under section 223, 225(b), 202(d), 202(e) or 202(f) of the Social Security Act. The purpose of this provision is to make VR services more readily available to disabled individuals, help State VR agencies and alternate participants to recover some of their costs in VR refusal situations as described in § 404.2113, and ensure that savings accrue to the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund. Payment will be made for VR services provided on behalf of such an individual in cases where—

(a) The furnishing of the VR services results in the individual's completion of a continuous 9-month period of substantial gainful activity (SGA) as specified in §§ 404.2110 through 404.2111;

(b) The individual continues to receive disability payments from us, even though his or her disability has ceased, because of his or her continued participation in an approved VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls (see § 404.2112); or

(c) The individual refuses, without good cause, to continue or to cooperate in a VR program in such a manner as to preclude his or her successful rehabilitation (see § 404.2113).

[55 FR 8453, Mar. 8, 1990]

§ 404.2102 Purpose and scope.

This subpart describes the rules under which the Commissioner will pay the State VR agencies or alternate participants for VR services. Payment will be provided for VR services provided on behalf of disabled individuals under one or more of the three provisions discussed in § 404.2101.

(a) Sections 404.2101 through 404.2103 describe the purpose of these regulations and the meaning of terms we frequently use in them.

(b) Section 404.2104 explains how State VR agencies or alternate participants may participate in the payment program under this subpart.

(c) Section 404.2106 describes the basic qualifications for alternate participants.

(d) Sections 404.2108 through 404.2109 describe the requirements and conditions under which we will pay a State VR agency or alternate participant under this subpart.

(e) Sections 404.2110 through 404.2111 describe when an individual has completed a continuous period of SGA and when VR services will be considered to have contributed to that period.

(f) Sections 404.2112 and 404.2113 describe when payment will be made to a VR agency or alternate participant because an individual's disability benefits are continued based on his or her participation in a VR program which we have determined will increase the likelihood that he or she will not return to the disability rolls; and when payment will be made to a VR agency

or alternate participant when an individual, without good cause, refuses to continue to participate in a VR program or fails to cooperate in such a manner as to preclude his or her successful rehabilitation.

(g) Sections 404.2114 through 404.2115 describe services for which payment will be made.

(h) Section 404.2116 describes the filing deadlines for claims for payment for VR services.

(i) Section 404.2117 describes the payment conditions.

(j) Section 404.2118 describes the applicability of these regulations to alternate participants.

(k) Section 404.2119 describes how we will make payment to State VR agencies or alternate participants for rehabilitation services.

(l) Sections 404.2120 and 404.2121 describe the audits and the prepayment and postpayment validation reviews we will conduct.

(m) Section 404.2122 discusses confidentiality of information and records.

(n) Section 404.2123 provides for the applicability of other Federal laws and regulations.

(o) Section 404.2127 provides for the resolution of disputes.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994; 62 FR 38452, July 18, 1997]

§ 404.2103 Definitions.

For purposes of this subpart:

Accept the beneficiary as a client for VR services means that the State VR agency determines that the individual is eligible for VR services and places the individual into an active caseload status for development of an individualized written rehabilitation program.

Act means the Social Security Act, as amended.

Alternate participants means any public or private agencies (except participating State VR agencies (see § 404.2104)), organizations, institutions, or individuals with whom the Commissioner has entered into an agreement or contract to provide VR services.

Commissioner means the Commissioner of Social Security or the Commissioner's designee.

Disability means ''disability'' or ''blindness'' as defined in sections 216(i) and 223 of the Act.

Disability beneficiary means a disabled individual who is entitled to benefits under section 223, 202(d), 202(e) or 202(f) of the act or is continuing to receive payment under section 225(b) of the Act after his or her disabling physical or mental impairments have ceased.

Good cause for VR refusal (as described in § 404.2113) is defined in § 404.422(e) of this part.

Medical recovery for purposes of this subpart is established when a beneficiary's disability entitlement ceases for any medical reason (other than death). The determination of medical recovery is made by the Commissioner in deciding a beneficiary's continuing entitlement to benefits.

Place the beneficiary into an extended evaluation process means that the State VR agency determines that an extended evaluation of the individual's VR potential is necessary to determine whether the individual is eligible for VR services and places the individual into an extended evaluation status.

SGA means substantial gainful activity performed by an individual as defined in §§ 404.1571 through 404.1575 or § 404.1584 of this subpart.

State means any of the 50 States of the United States, the Commonwealth of Puerto Rico, the District of Columbia, the Virgin Islands, or Guam. It includes the State VR agency.

Trust Funds means the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund.

Vocational rehabilitation services has the meaning assigned to it under title I of the Rehabilitation Act of 1973.

VR agency means an agency of the State which has been designated by the State to provide vocational rehabilitation services under title I of the Rehabilitation Act of 1973.

Waiting period means a five consecutive calendar month period throughout which an individual must be under a disability and which must be served before disability benefits can be paid (see § 404.315(d)).

We, us and our refer to the Social Security Administration (SSA).

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11912, Mar. 15, 1994; 62 FR 38452, July 18, 1997]

§ 404.2104 Participation by State VR agencies or alternate participants.

(a) *General.* In order to participate in the payment program under this subpart through its VR agency(ies), a State must have a plan which meets the requirements of title I of the Rehabilitation Act of 1973, as amended. An alternate participant must have a similar plan and otherwise qualify under § 404.2106.

(b) *Participation by States.* (1) The opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State will be offered first to the State in accordance with paragraph (c) of this section, unless the State has notified us in advance under paragraph (e)(1) of this section of its decision not to participate or to limit such participation.

(2) A State with one or more approved VR agencies may choose to limit participation of those agencies to a certain class(es) of disability beneficiaries. For example, a State with separate VR agencies for the blind and disabled may choose to limit participation to the VR agency for the blind. In such a case, we would give the State, through its VR agency for the blind, the opportunity to participate with respect to blind disability beneficiaries in the State in accordance with paragraph (d) of this section. We would arrange for VR services for non-blind disability beneficiaries in the State through an alternate participant(s). A State that chooses to limit participation of its VR agency(ies) must notify us in advance under paragraph (e)(1) of this section of its decision to limit such participation.

(3) If a State chooses to participate by using a State agency other than a VR agency with a plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, that State agency may participate only as an alternate participant.

(c) *Opportunity for participation through State VR agencies.* (1) Unless a State has decided not to participate or to limit participation, we will give the State the opportunity to participate through its VR agency(ies) with respect to disability beneficiaries in the State by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. A State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(2)(i) In order for the State to participate with respect to a disability beneficiary whom we referred to a State VR agency, the State VR agency must notify the appropriate Regional Commissioner (SSA) in writing or through electronic notification of its decision either to accept the beneficiary as a client for VR services or to place the beneficiary into an extended evaluation process. The notice must be received by the appropriate Regional Commissioner (SSA) no later than the close of the fourth month following the month in which we referred the beneficiary to the State VR agency. If we do not receive such notice with respect to a beneficiary whom we referred to the State VR agency, we may arrange for VR services for that beneficiary through an alternate participant.

(ii) In any case in which a State VR agency notifies the appropriate Regional Commissioner (SSA) in writing within the stated time period under paragraph (c)(2)(i) of this section of its decision to place the beneficiary into an extended evaluation process, the State VR agency also must notify that Regional Commissioner in writing upon completion of the evaluation of its decision whether or not to accept the beneficiary as a client for VR services. If we receive a notice of a decision by the State VR agency to accept the beneficiary as a client for VR services following the completion of the extended evaluation, the State may continue to participate with respect to such beneficiary. If we receive a notice of a decision by the State VR agency

not to accept the beneficiary as a client for VR services following the completion of the extended evaluation, we may arrange for VR services for that beneficiary through an alternate participant.

(d) *Opportunity for limited participation through State VR agencies.* If a State has decided under paragraph (e)(1) of this section to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries in the State, we will give the State the opportunity to participate with respect to such class(es) of disability beneficiaries by referring such beneficiaries first to the State VR agency(ies) for necessary VR services. The State, through its VR agency(ies), may participate with respect to any beneficiary so referred by accepting the beneficiary as a client for VR services or placing the beneficiary into an extended evaluation process and notifying us under paragraph (c)(2) of this section of such acceptance or placement.

(e) *Decision of a State not to participate or to limit participation.* (1) A State may choose not to participate through its VR agency(ies) with respect to any disability beneficiaries in the State, or it may choose to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries in the State. A State which decides not to participate or to limit participation must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a State specifies a later month, a decision not to participate or to limit participation will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA). The notice of the State decision must be submitted by an official authorized to act for the State for this purpose. A State must provide to the appropriate Regional Commissioner (SSA) an opinion from the State's Attorney General verifying the authority of the official who sent the notice to act for the State. This opinion will not be necessary if the notice is signed by the Governor of the State.

(2)(i) If a State has decided not to participate through its VR agency(ies), we may arrange for VR services through an alternate participant(s) for disability beneficiaries in the State.

(ii) If a State has decided to limit participation of its VR agency(ies) to a certain class(es) of disability beneficiaries, we may arrange for VR services through an alternate participant(s) for the class(es) of disability beneficiaries in the State excluded from the scope of the State's participation.

(3) A State which has decided not to participate or to limit participation may participate later through its VR agency(ies) in accordance with paragraph (c) of this section, provided that such participation will not conflict with any previous commitment which we may have made to an alternate participant(s) under paragraph (e)(2) of this section. A State which decides to resume participation under paragraph (c) of this section must provide advance written notice of that decision to the appropriate Regional Commissioner (SSA). Unless a commitment to an alternate participant(s) requires otherwise, a decision of a State to resume participation under paragraph (c) of this section will be effective beginning with the third month following the month in which the notice of the decision is received by the appropriate Regional Commissioner (SSA) or, if later, with a month specified by the State. The notice of the State decision must be submitted by an official authorized to act for the State as explained in paragraph (e)(1) of this section.

(f) *Use of alternate participants.* The Commissioner, by written agreement or contract, may arrange for VR services through an alternate participant(s) for any disability beneficiary in the State with respect to whom the State is unwilling to participate through its VR agency(ies). In such a case, we may refer the beneficiary to such alternate participant for necessary VR services. The Commissioner will find that a State is unwilling to participate with respect to any of the following disability beneficiaries in that State:

(1) A disability beneficiary whom we referred to a State VR agency under paragraph (c) or (d) of this section if we

do not receive a notice within the stated time period under paragraph (c)(2)(i) of this section of a decision by the VR agency either to accept the beneficiary as a client for VR services or to place the beneficiary into an extended evaluation process;

(2) A disability beneficiary with respect to whom we receive a notice under paragraph (c)(2)(ii) of this section of a decision by the VR agency not to accept the beneficiary as a client for VR services following the completion of the extended evaluation;

(3) The class(es) of disability beneficiaries excluded from the scope of the State's participation if the State has decided to limit participation of its VR agency(ies); and

(4) All disability beneficiaries in the State if the State has decided not to participate through its VR agency(ies).

[59 FR 11912, Mar. 15, 1994]

§ 404.2106 Basic qualifications for alternate participants.

(a) *General.* We may arrange for VR services through an alternate participant by written agreement or contract as explained in § 404.2104(f). An alternate participant may be a public or private agency, organization, institution or individual (that is, any entity whether for-profit or not-for-profit), other than a State VR agency.

(1) An alternate participant must—

(i) Be licensed, certified, accredited, or registered, as appropriate, to provide VR services in the State in which it provides services; and

(ii) Under the terms of the written contract or agreement, have a plan similar to the State plan described in § 404.2104(a) which shall govern the provision of VR services to individuals.

(2) We will not use as an alternate participant any agency, organization, institution, or individual—

(i) Whose license, accreditation, certification, or registration is suspended or revoked for reasons concerning professional competence or conduct or financial integrity;

(ii) Who has surrendered such license, accreditation, certification, or registration pending a final determination of a formal disciplinary proceeding; or

(iii) Who is precluded from Federal procurement or nonprocurement programs.

(b) *Standards for the provision of VR services.* An alternate participant's plan must provide, among other things, that the provision of VR services to individuals will meet certain minimum standards, including, but not limited to, the following:

(1) All medical and related health services furnished will be prescribed by, or provided under the formal supervision of, persons licensed to prescribe or supervise the provision of these services in the State;

(2) Only qualified personnel and rehabilitation facilities will be used to furnish VR services; and

(3) No personnel or rehabilitation facility described in paragraph (a)(2) (i), (ii), or (iii) of this section will be used to provide VR services.

[59 FR 11914, Mar. 15, 1994]

PAYMENT PROVISIONS

§ 404.2108 Requirements for payment.

(a) The State VR agency or alternate participant must file a claim for payment in each individual case within the time periods specified in § 404.2116;

(b) The claim for payment must be in a form prescribed by us and contain the following information:

(1) A description of each service provided;

(2) When the service was provided; and

(3) The cost of the service;

(c) The VR services for which payment is being requested must have been provided during the period specified in § 404.2115;

(d) The VR services for which payment is being requested must have been provided under a State plan for VR services approved under title I of the Rehabilitation Act of 1973, as amended, or, in the case of an alternate participant, under a negotiated plan, and must be services that are described in § 404.2114;

(e) The individual must meet one of the VR payment provisions specified in § 404.2101;

(f) The State VR agency or alternate participant must maintain, and provide

as we may require, adequate documentation of all services and costs for all disability beneficiaries with respect to whom a State VR agency or alternate participant could potentially request payment for services and costs under this subpart; and

(g) The amount to be paid must be reasonable and necessary and be in compliance with the cost guidelines specified in §404.2117.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990; 59 FR 11914, Mar. 15, 1994

§404.2109 Responsibility for making payment decisions.

The Commissioner will decide—

(a) Whether a continuous period of 9 months of SGA has been completed;

(b) Whether a disability beneficiary whose disability has ceased should continue to receive benefits under §404.316(c), 404.337(c), or 404.352(c) for a month after October 1984, based on his or her continued participation in a VR program;

(c) Whether an individual, without good cause, refused to continue to accept VR services or failed to cooperate in a VR program for a month(s) after October 1984, and whether deductions should be imposed against the individual's disability benefits;

(d) If and when medical recovery has occurred;

(e) Whether documentation of VR services and expenditures is adequate;

(f) If payment is to be based on completion of a continuous 9-month period of SGA, whether the VR services contributed to the continuous period of SGA;

(g) Whether a VR service is a service described in §404.2114; and

(h) What VR costs were reasonable and necessary and will be paid.

[55 FR 8454, Mar. 8, 1990, as amended at 59 FR 11914, Mar. 15, 1994]

§404.2110 What we mean by "SGA" and by "a continuous period of 9 months".

(a) *What we mean by ''SGA''.* In determining whether an individual's work is SGA, we will follow the rules in §§404.1572 through 404.1575. We will follow these same rules for individuals who are statutorily blind, but we will evaluate the earnings in accordance with the rules in §404.1584(d).

(b) *What we mean by ''a continuous period of 9 months''.* A continuous period of 9 months ordinarily means a period of 9 consecutive calendar months. Exception: When an individual does not perform SGA in 9 consecutive calendar months, he or she will be considered to have done so if—

(1) The individual performs 9 months of SGA within 10 consecutive months and has monthly earnings that meet or exceed the guidelines in §404.1574(b)(2), or §404.1584(d) if the individual is statutorily blind; or

(2) The individual performs at least 9 months of SGA within 12 consecutive months, and the reason for not performing SGA in 2 or 3 of those months was due to circumstances beyond his or her control and unrelated to the impairment (e.g., the employer closed down for 3 months).

(c) *What work we consider.* In determining if a continuous period of SGA has been completed, all of an individual's work activity may be evaluated for purposes of this section, including work performed before October 1981, during the waiting period, during the trial work period and after entitlement to disability benefits terminated. We will ordinarily consider only the first 9 months of SGA that occur. The exception will be if an individual who completed 9 months of SGA later stops performing SGA, receives VR services and then performs SGA for a 9-month period. See §404.2115 for the use of the continuous period in determining payment for VR services.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8454, Mar. 8, 1990]

§404.2111 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.

The State VR agency or alternate participant may be paid for VR services if such services contribute to the individual's performance of a continuous 9-month period of SGA. The following criteria apply to individuals who received more than just evaluation services. If a State VR agency or alternate participant claims payment for services to an individual who received

only evaluation services, it must establish that the individual's continuous period or medical recovery (if medical recovery occurred before completion of a continuous period) would not have occurred without the services provided. In applying the criteria below, we will consider services described in § 404.2114 that were initiated, coordinated or provided, including services before October 1, 1981.

(a) *Continuous period without medical recovery*. If an individual who has completed a ''continuous period'' of SGA has not medically recovered as of the date of completion of the period, the determination as to whether VR services contributed will depend on whether the continuous period began one year or less after VR services ended or more than one year after VR services ended.

(1) *One year or less.* Any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(2) *More than one year.* (i) If the continuous period was preceded by transitional work activity (employment or self-employment which gradually evolved, with or without periodic interruption, into SGA), and that work activity began less than a year after VR services ended, any VR services which significantly motivated or assisted the individual in returning to, or continuing in, SGA will be considered to have contributed to the continuous period.

(ii) If the continuous period was not preceded by transitional work activity that began less than a year after VR services ended, VR services will be considered to have contributed to the continuous period only if it is reasonable to conclude that the work activity which constitutes a continuous period could not have occurred without the VR services (e.g., training).

(b) *Continuous period with medical recovery occurring before completion.* (1) If an individual medically recovers before a continuous period has been completed, VR services under paragraph (a) of this section will not be payable unless some VR services contributed to the medical recovery. VR services will be considered to have contributed to the medical recovery if—

(i) The individualized written rehabilitation program (IWRP) or, in the case of an alternate participant, a similar document, included medical services; and

(ii) The medical recovery occurred, at least in part, because of these medical services. (For example, the individual's medical recovery was based on improvement in a back condition which, at least in part, stemmed from surgery initiated, coordinated or provided under an IWRP).

(2) In some instances, the State VR agency or alternate participant will not have provided, initiated, or coordinated medical services. If this happens, payment for VR services may still be possible under paragraph (a) of this section if: (i) The medical recovery was not expected by us; and (ii) the individual's impairment is determined by us to be of such a nature that any medical services provided would not ordinarily have resulted in, or contributed to, the medical cessation.

[48 FR 6293, Feb. 10, 1983, as amended at 59 FR 11914, Mar. 15, 1994]

§ 404.2112 Payment for VR services in a case where an individual continues to receive disability payments based on participation in an approved VR program.

Sections 404.1586(g), 404.316(c), 404.337(c), and 404.352(c) explain the criteria we will use in determining if an individual whose disability has ceased should continue to receive disability benefits from us because of his or her continued participation in a VR program. A VR agency or alternate participant can be paid for the cost of VR services provided to an individual if the individual was receiving benefits in a month or months, after October 1984, based on § 404.316(c), 404.337(c), or 404.352(c). If this requirement is met, a VR agency or alternate participant can be paid for the costs of VR services provided within the period specified in § 404.2115, subject to the other payment and administrative provisions of this subpart.

[55 FR 8455, Mar. 8, 1990]

§404.2113 Payment for VR services in a case of VR refusal.

(a) For purposes of this section, *VR refusal* means an individual's refusal to continue to accept VR services or failure to cooperate in such a manner as to preclude the individual's successful rehabilitation.

(b) No later than the 60th day after the State VR agency or alternate participant makes a preliminary finding that an individual refuses to continue to accept VR services or fails to cooperate in a VR program, the State VR agency or alternate participant shall report to the appropriate Regional Commissioner (SSA) in writing such individual's VR refusal so that we may make the determination described in §404.2109(c).

(c) Payment can be made to a State VR agency or alternate participant for the costs of VR services provided to an individual who, after filing an application with the State VR agency or alternate participant for rehabilitation services, without good cause, refuses to continue to accept VR services or fails to cooperate in such a manner as to preclude the individual's successful rehabilitation. A State VR agency or alternate participant may be paid, subject to the provisions of this subpart, for the costs of VR services provided to an individual prior to his or her VR refusal if deductions have been imposed against the individual's monthly disability benefits for a month(s) after October 1984 because of such VR refusal.

[59 FR 11915, Mar. 15, 1994, as amended at 61 FR 31025, June 19, 1996]

§404.2114 Services for which payment may be made.

(a) *General.* Payment may be made for VR services provided by a State VR agency in accordance with title I of the Rehabilitation Act of 1973, as amended, or by an alternate participant under a negotiated plan, subject to the limitations and conditions in this subpart. VR services for which payment may be made under this subpart include only those services described in paragraph (b) of this section which are—

(1) Necessary to determine an individual's eligibility for VR services or the nature and scope of the services to be provided; or

(2) Provided by a State VR agency under an IWRP, or by an alternate participant under a similar document, but only if the services could reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

(b) *Specific services.* Payment may be made under this subpart only for the following VR services:

(1) An assessment for determining an individual's eligibility for VR services and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology, and which includes determining—

(i) The nature and extent of the physical or mental impairment(s) and the resultant impact on the individual's employability;

(ii) The likelihood that an individual will benefit from vocational rehabilitation services in terms of employability; and

(iii) An employment goal consistent with the capacities of the individual and employment opportunities;

(2) Counseling and guidance, including personal adjustment counseling, and those referrals and other services necessary to help an individual secure needed services from other agencies;

(3) Physical and mental restoration services necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and which constitutes an impediment to suitable employment at or above the SGA level;

(4) Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials, except that training or training services in institutions of higher education will be covered under this section only if maximum efforts have been made by the State VR agency or alternate participant to secure grant assistance in whole or in part from other sources;

(5) Maintenance expenses that are extra living expenses over and above the individual's normal living expenses and that are incurred solely because of and while the individual is participating in the VR program and that are necessary in order for the individual to

benefit from other necessary VR services;

(6) Travel and related expenses necessary to transport an individual for purpose of enabling the individual's participation in other necessary VR services;

(7) Services to family members of a disabled individual only if necessary to the successful vocational rehabilitation of that individual;

(8) Interpreter services and note-taking services for an individual who is deaf and tactile interpreting for an individual who is deaf and blind;

(9) Reader services, rehabilitation teaching services, note-taking services, and orientation and mobility services for an individual who is blind;

(10) Telecommunications, sensory, and other technological aids and devices;

(11) Work-related placement services to secure suitable employment;

(12) Post-employment services necessary to maintain, regain or advance into suitable employment at or above the SGA level;

(13) Occupational licenses, tools, equipment, initial stocks, and supplies;

(14) Rehabilitation technology services; and

(15) Other goods and services that can reasonably be expected to motivate or assist the individual in returning to, or continuing in, SGA.

[59 FR 11915, Mar. 15, 1994]

§ 404.2115 When services must have been provided.

(a) In order for the VR agency or alternate participant to be paid, the services must have been provided—

(1) After September 30, 1981;

(2) No earlier than the beginning of the waiting period or the first month of entitlement, if no waiting period is required; and

(3) Before completion of a continuous 9-month period of SGA or termination of entitlement to disability benefits, whichever occurs first.

(b) If an individual who is entitled to disability benefits under this part also is or has been receiving disability or blindness benefits under part 416 of this chapter, the determination as to when services must have been provided may be made under this section or § 416.2215 of this chapter, whichever is advantageous to the State VR agency or alternate participant that is participating in both VR programs.

[55 FR 8455, Mar. 8, 1990, as amended at 61 FR 31025, June 19, 1996]

§ 404.2116 When claims for payment for VR services must be made (filing deadlines).

The State VR agency or alternate participant must file a claim for payment in each individual case within the following time periods:

(a) A claim for payment for VR services based on the individual's completion of a continuous 9-month period of SGA must be filed within 12 months after the month in which the continuous 9-month period of SGA is completed.

(b) A claim for payment for VR services provided to an individual whose disability benefits were continued after disability has ceased because of that individual's continued participation in a VR program must be filed as follows:

(1) If a written notice requesting that a claim be filed was sent to the State VR agency or alternate participant, a claim must be filed within 90 days following the month in which VR services end, or if later, within 90 days after receipt of the notice.

(2) If no written notice was sent to the State VR agency or alternate participant, a claim must be filed within 12 months after the month in which VR services end.

(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 first month for which deductions are imposed against disability benefits because of such VR refusal.

[55 FR 8455, Mar. 8, 1990, as amended at 61 FR 31025, June 19, 1996]

§404.2117 What costs will be paid.

In accordance with section 222(d) of the Social Security Act, the Commissioner will pay the State VR agency or alternate participant for the VR services described in §404.2114 which were provided during the period described in §404.2115 and which meet the criteria in §404.2111, §404.2112, or §404.2113, but subject to the following limitations:

(a) The cost must have been incurred by the State VR agency or alternate participant;

(b) The cost must not have been paid or be payable from some other source. For this purpose, State VR agencies or alternate participants will be required to seek payment or services from other sources in accordance with the ''similar benefit'' provisions under 34 CFR part 361, including making maximum efforts to secure grant assistance in whole or part from other sources for training or training services in institutions of higher education. Alternate participants will not be required to consider State VR services a similar benefit.

(c)(1) The cost must be reasonable and necessary, in that it complies with the written cost-containment policies of the State VR agency or, in the case of an alternate participant, it complies with similar written policies established under a negotiated plan. A cost which complies with these policies will be considered necessary only if the cost is for a VR service described in §404.2114. The State VR agency or alternate participant must maintain and use these cost-containment policies, including any reasonable and appropriate fee schedules, to govern the costs incurred for all VR services, including the rates of payment for all purchased services, for which payment will be requested under this subpart. For the purpose of this subpart, the written cost-containment policies must provide guidelines designed to ensure—

(i) The lowest reasonable cost for such services; and

(ii) Sufficient flexibility so as to allow for an individual's needs.

(2) The State VR agency shall submit to us before the end of the first calendar quarter of each year a written statement certifying that cost-containment policies are in effect and are adhered to in procuring and providing goods and services for which the State VR agency requests payment under this subpart. Such certification must be signed by the State's chief financial official or the head of the VR agency. Each certification must specify the basis upon which it is made, e.g., a recent audit by an authorized State, Federal or private auditor (or other independent compliance review) and the date of such audit (or compliance review). In the case of an alternate participant, these certification requirements shall be incorporated into the negotiated agreement or contract. We may request the State VR agency or alternate participant to submit to us a copy(ies) of its specific written cost-containment policies and procedures (e.g., any guidelines and fee schedules for a given year) if we determine that such additional information is necessary to ensure compliance with the requirements of this subpart. The State VR agency or alternate participant shall provide such information when requested by us.

(d) The total payment in each case, including any prior payments related to earlier continuous 9-month periods of SGA made under this subpart, must not be so high as to preclude a ''net saving'' to the trust funds (a ''net saving'' is the difference between the estimated saving to the trust funds, if disability benefits eventually terminate, and the total amount we pay to the State VR agency or alternate participant);

(e) Any payment to the State VR agency for either direct or indirect VR expenses must be consistent with the cost principles described in OMB Circular No. A–87, published at 46 FR 9548 on January 28, 1981 (see §404.2118(a) for cost principles applicable to alternate participants);

(f) Payment for VR services or costs may be made under more than one of the VR payment provisions described in §§404.2111 through 404.2113 of this subpart and similar provisions in §§416.2211 through 416.2213 of subpart V of part 416. However, payment will not be made more than once for the same VR service or cost. For example, payment to a VR agency based upon the

completion of a continuous 9-month period of SGA which was made after an earlier payment based upon VR refusal, would only include payment for those VR costs incurred or services provided after the individual resumed VR services after refusal; and

(g) Payment will be made for administrative costs and for counseling and placement costs. This payment may be on a formula basis, or on an actual cost basis, whichever the State VR agency prefers. The formula will be negotiated. The payment will also be subject to the preceding limitations.

[48 FR 6293, Feb. 10, 1983. Redesignated and amended at 55 FR 8454, 8455, Mar. 8, 1990; 59 FR 11915, Mar. 15, 1994; 62 FR 38452, July 18, 1997]

ADMINISTRATIVE PROVISIONS

§ 404.2118 Applicability of these provisions to alternate participants.

When an alternate participant provides rehabilitation services under this subpart, the payment procedures stated herein shall apply except that:

(a) Payment must be consistent with the cost principles described in 45 CFR part 74 or 41 CFR parts 1–15 as appropriate; and

(b) Any disputes, including appeals of audit determinations, shall be resolved in accordance with applicable statutes and regulations which will be specified in the negotiated agreement or contract.

[48 FR 6293, Feb. 10, 1983. Redesignated at 55 FR 8454, Mar. 8, 1990]

§ 404.2119 Method of payment.

Payment to the State VR agencies or alternate participants pursuant to this subpart will be made either by advancement of funds or by payment for services provided (with necessary adjustments for any overpayments and underpayments), as decided by the Commissioner.

[55 FR 8455, Mar. 8, 1990]

§ 404.2120 Audits.

(a) *General.* The State or alternate participant shall permit us and the Comptroller General of the United States (including duly authorized representatives) access to and the right to examine records relating to the services and costs for which payment was requested or made under these regulations. These records shall be retained by the State or alternate participant for the periods of time specified for retention of records in the Federal Procurement Regulations (41 CFR parts 1–20).

(b) *Audit basis.* Auditing will be based on cost principles and written guidelines in effect at the time services were provided and costs were incurred. The State VR agency or alternate participant will be informed and given a full explanation of any questioned items. It will be given a reasonable time to explain questioned items. Any explanation furnished by the State VR agency or alternate participant will be given full consideration before a final determination is made on questioned items in the audit report.

(c) *Appeal of audit determinations.* The appropriate SSA Regional Commissioner will notify the State VR agency or alternate participant in writing of his or her final determination on the audit report. If the State VR agency (see § 404.2118(b) for alternate participants) disagrees with that determination, it may request reconsideration in writing within 60 days after receiving the Regional Commissioner's notice of the determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually, no later than 45 days from the date of appeal. The decision by the Commissioner will be final and conclusive unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental Appeals Board within 30 days after receiving it.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 62 FR 38452, July 18, 1997]

§ 404.2121 Validation reviews.

(a) *General.* We will conduct a validation review of a sample of the claims for payment filed by each State VR agency or alternate participant. We will conduct some of these reviews on a prepayment basis and some on a postpayment basis. We may review a specific claim, a sample of the claims,

or all the claims filed by any State VR agency or alternate participant, if we determine that such review is necessary to ensure compliance with the requirements of this subpart. For each claim selected for review, the State VR agency or alternate participant must submit such records of the VR services and costs for which payment has been requested or made under this subpart, or copies of such records, as we may require to ensure that the services and costs meet the requirements for payment. For claims for cases described in §404.2101(a), a clear explanation or existing documentation which demonstrates how the service contributed to the individual's performance of a continuous 9-month period of SGA must be provided. For claims for cases described in §404.2101 (b) or (c), a clear explanation or existing documentation which demonstrates how the service was reasonably expected to motivate or assist the individual to return to or continue in SGA must be provided. If we find in any prepayment validation review, that the scope or content of the information is inadequate, we will request additional information and will withhold payment until adequate information has been provided. The State VR agency or alternate participant shall permit us (including duly authorized representatives) access to, and the right to examine, any records relating to such services and costs. Any review performed under this section will not be considered an audit for purposes of this subpart.

(b) *Purpose.* The primary purpose of these reviews is—

(1) To ensure that the VR services and costs meet the requirements for payment under this subpart;

(2) To assess the validity of our documentation requirements; and

(3) To assess the need for additional validation reviews or additional documentation requirements for any State VR agency or alternate participant to ensure compliance with the requirements under this subpart.

(c) *Determinations.* In any validation review, we will determine whether the VR services and costs meet the requirements for payment and determine the amount of payment. We will notify in writing the State VR agency or alternate participant of our determination. If we find in any postpayment validation review that more or less than the correct amount of payment was made for a claim, we will determine that an overpayment or underpayment has occurred and will notify the State VR agency or alternate participant that we will make the appropriate adjustment.

(d) *Appeals.* If the State VR agency or alternate participant disagrees with our determination under this section, it may appeal that determination in accordance with §404.2127. For purposes of this section, an appeal must be filed within 60 days after receiving the notice of our determination.

[59 FR 11916, Mar. 15, 1994]

§404.2122 Confidentiality of information and records.

The State or alternate participant shall comply with the provisions for confidentiality of information, including the security of systems, and records requirements described in 20 CFR part 401 and pertinent written guidelines (see §404.2123).

§404.2123 Other Federal laws and regulations.

Each State VR agency and alternate participant shall comply with the provisions of other Federal laws and regulations that directly affect its responsibilities in carrying out the vocational rehabilitation function.

§404.2127 Resolution of disputes.

(a) *Disputes on the amount to be paid.* The appropriate SSA official will notify the State VR agency or alternative participant in writing of his or her determination concerning the amount to be paid. If the State VR agency (see §404.2118(b) for alternate participants) disagrees with that determination, the State VR agency may request reconsideration in writing within 60 days after receiving the notice of determination. The Commissioner will make a determination and notify the State VR agency of that decision in writing, usually no later than 45 days from the date of the State VR agency's appeal. The decision by the Commissioner will be final and conclusive upon the State VR

agency unless the State VR agency appeals that decision in writing in accordance with 45 CFR part 16 to the Department of Health and Human Services' Departmental 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 Departmental Appeals Board.

(c) *Disputes on determinations made by the Commissioner which affect a disability beneficiary's rights to benefits.* Determinations made by the Commissioner which affect an individual's right to benefits (e.g., determinations that disability benefits should be terminated, denied, suspended, continued or begun at a different date than alleged) cannot be appealed by a State VR agency or alternate participant. Because these determinations are an integral part of the disability benefits claims process, they can only be appealed by the beneficiary or applicant whose rights are affected or by his or her authorized representative. However, if an appeal of an unfavorable determination is made by the individual and is successful, the new determination would also apply for purposes of this subpart. While a VR agency or alternate participant cannot appeal a determination made by the Commissioner which affects a beneficiary's or applicant's rights, the VR agency can furnish any evidence it may have which would support a revision of a determination.

[48 FR 6293, Feb. 10, 1983, as amended at 55 FR 8456, Mar. 8, 1990; 62 FR 38452, July 18, 1997]

PART 410—FEDERAL COAL MINE HEALTH AND SAFETY ACT OF 1969, TITLE IV—BLACK LUNG BENEFITS (1969–)

Subpart A—Introduction, General Provisions, and Definitions

Sec.

410.101 Introduction.
410.110 General definitions and use of terms.
410.120 Disclosure of program information.
410.130 Periods of limitation ending on nonworkdays.

Subpart B—Requirements for Entitlement; Duration of Entitlement; Filing of Claims and Evidence

410.200 Types of benefits; general.
410.201 Conditions of entitlement; miner.
410.202 Duration of entitlement; miner.
410.210 Conditions of entitlement; widow or surviving divorced wife.
410.211 Duration of entitlement; widow or surviving divorced wife.
410.212 Conditions of entitlement; child.
410.213 Duration of entitlement; child.
410.214 Conditions of entitlement; parent, brother, or sister.
410.215 Duration of entitlement; parent, brother, or sister.
410.216 ''Good cause'' for delayed filing of proof of support.
410.219 Filing a claim under State workmen's compensation law; when filing such claim shall be considered futile.
410.220 Claim for benefits; definitions.
410.221 Prescribed application and request forms.
410.222 Execution of a claim.
410.223 Evidence of authority to execute a claim on behalf of another.
410.224 Claimant must be alive when claim is filed.
410.226 Periods for which claims are effective.
410.227 When a claim is considered to have been filed; time and place of filing.
410.228 Requests and notices to be in writing.
410.229 When written statement is considered a claim; general.
410.230 Written statement filed by or for a miner on behalf of a member of his family.
410.231 Time limits for filing claims.
410.232 Withdrawal of a claim.
410.233 Cancellation of a request for withdrawal.
410.234 Interim provisions.
410.240 Evidence.
410.250 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

Subpart C—Relationship and Dependency

410.300 Relationship and dependency; general.
410.310 Determination of relationship; wife.
410.311 Determination of relationship; divorced wife.
410.320 Determination of relationship; widow.
410.321 Determination of relationship; surviving divorced wife.
410.330 Determination of relationship; child.

410.340 Determination of relationship; parent, brother, or sister.
410.350 Determination of dependency; wife.
410.351 Determination of dependency; divorced wife.
410.360 Determination of dependency; widow.
410.361 Determination of dependency; surviving divorced wife.
410.370 Determination of dependency; child.
410.380 Determination of dependency; parent, brother, or sister.
410.390 Time of determinations.
410.391 Legal impediment.
410.392 Domicile.
410.393 ''Member of the same household''; ''living with''; ''living in the same household''; and ''living in the miner's household''.
410.394 [Reserved]
410.395 Contributions and support.

Subpart D—Total Disability or Death Due to Pneumoconiosis

410.401 Scope of subpart D.
410.410 Total disability due to pneumoconiosis, including statutory presumption.
410.412 ''Total disability'' defined.
410.414 Determining the existence of pneumoconiosis, including statutory presumption.
410.416 Determining origin of pneumoconiosis, including statutory presumption.
410.418 Irrebuttable presumption of total disability due to pneumoconiosis.
410.422 Determining total disability: General criteria.
410.424 Determining total disability: Medical criteria only.
410.426 Determining total disability: Age, education, and work experience criteria.
410.428 X-ray, biopsy, and autopsy evidence of pneumoconiosis.
410.430 Ventilatory studies.
410.432 Cessation of disability.
410.450 Death due to pneumoconiosis, including statutory presumption.
410.454 Determining the existence of pneumoconiosis, including statutory presumption—survivor's claim.
410.456 Determining origin of pneumoconiosis, including statutory presumption—survivor's claim.
410.458 Irrebuttable presumption of death due to pneumoconiosis—survivor's claim.
410.462 Presumption relating to respirable disease.
410.470 Determination by nongovernmental organization or other governmental agency.
410.471 Conclusion by physician regarding miner's disability or death.
410.472 Consultative examinations.
410.473 Evidence of continuation of disability.
410.474 Place and manner of submitting evidence.
410.475 Failure to submit evidence.
410.476 Responsibility to give notice of event which may affect a change in disability status.
410.490 Interim adjudicatory rules for certain part B claims filed by a miner before July 1, 1973, or by a survivor where the miner died before January 1, 1974.
APPENDIX TO SUBPART D

Subpart E—Payment of Benefits

410.501 Payment periods.
410.505 Payees.
410.510 Computation of benefits.
410.511 Certification to dependent of augmentation portion of benefit.
410.515 Modification of benefit amounts; general.
410.520 Reductions; receipt of State benefit.
410.530 Reductions; excess earnings.
410.535 Reductions; effect of an additional claim for benefits.
410.536 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.
410.540 Reductions; more than one reduction event.
410.550 Nonpayment of benefits to residents of certain States.
410.560 Overpayments.
410.561 Notice of right to waiver consideration.
410.561a When waiver may be applied and how to process the request.
410.561b Fault.
410.561c Defeat the purpose of title IV.
410.561d Against equity and good conscience; defined.
410.561e When an individual is ''without fault'' in a reduction-overpayment.
410.561f When an individual is ''without fault'' in an entitlement overpayment.
410.561g When an individual is at ''fault'' in a reduction-overpayment.
410.561h When adjustment or recovery of an overpayment will be waived.
410.563 Liability of a certifying officer.
410.565 Collection and compromise of claims for overpayment.
410.570 Underpayments.
410.580 Relation to provisions for reductions or increases.
410.581 Payments on behalf of an individual.
410.582 Submission of evidence by representative payee.
410.583 Responsibility of representative payee.
410.584 Use of benefits for current maintenance.
410.585 Conservation and investment of payments.

410.586 Use of benefits for beneficiary in institution.
410.587 Support of legally dependent spouse, child, or parent.
410.588 Claims of creditors.
410.589 Accountability.
410.590 Transfer of accumulated benefit payments.
410.591 Eligibility for services and supplies under part C of title IV of the act.

Subpart F—Determinations of Disability, Other Determinations, Administrative Review, Finality of Decisions, and Representation of Parties

410.601 Determinations of disability.
410.610 Administrative actions that are initial determinations.
410.615 Administrative actions that are not initial determinations.
410.620 Notice of initial determination.
410.621 Effect of initial determination.
410.622 Reconsideration and hearing.
410.623 Reconsideration; right to reconsideration.
410.624 Time and place of filing request.
410.625 Parties to the reconsideration.
410.626 Notice of reconsideration.
410.627 Reconsidered determination.
410.628 Notice of reconsidered determination.
410.629 Effect of a reconsidered determination.
410.629a Expedited appeals process; conditions for use of such process.
410.629b Expedited appeals process; place and time of filing request.
410.629c Expedited appeals process; parties.
410.629d Expedited appeals process; agreement requirements.
410.629e Expedited appeals process; effect of agreement.
410.629f Effect of a request that does not result in agreement.
410.630 Hearing; right to hearing.
410.631 Time and place of filing request.
410.632 Parties to a hearing.
410.633 Additional parties to the hearing.
410.634 Administrative Law Judge.
410.635 Disqualification of Administrative Law Judge.
410.636 Time and place of hearing.
410.637 Hearing on new issues.
410.638 Change of time and place for hearing.
410.639 Subpenas.
410.640 Conduct of hearing.
410.641 Evidence.
410.642 Witnesses.
410.643 Oral argument and written allegations.
410.644 Record of hearing.
410.645 Joint hearings.
410.646 Consolidated issues.
410.647 Waiver of right to appear and present evidence.
410.648 Dismissal of request for hearing; by application of party.
410.649 Dismissal by abandonment of party.
410.650 Dismissal for cause.
410.651 Notice of dismissal and right to request review thereon.
410.652 Effect of dismissal.
410.653 Vacation of dismissal of request for hearing.
410.654 Administrative Law Judge's decision or certification to Appeals Council.
410.655 Effect of Administrative Law Judge's decision.
410.656 Removal of hearing to Appeals Council.
410.657 Appeals Council proceedings on certification and review; procedure before Appeals Council on certification by the Administrative Law Judge.
410.658 Evidence in proceeding before Appeals Council.
410.659 Decision of Appeals Council.
410.660 Right to request review of Administrative Law Judge's decision or dismissal.
410.661 Time and place of filing request.
410.662 Action by Appeals Council on review.
410.663 Procedure before Appeals Council on review.
410.664 Evidence admissible on review.
410.665 Decision by Appeals Council or remanding of case.
410.666 Effect of Appeals Council's decision or refusal to review.
410.667 Dismissal by Appeals Council.
410.668 Extension of time to request reconsideration.
410.669 Extension of time to request hearing or review or begin civil action.
410.670 Review by Appeals Council.
410.670a Judicial review.
410.670b Interim provision for the adjudication of certain claims filed prior to May 19, 1972.
410.670c Application of circuit court law.
410.671 Revision for error or other reason; time limitation generally.
410.672 Reopening initial, revised or reconsidered determinations of the Administration and decisions of an Administrative Law Judge or the Appeals Council; finality of determinations and decisions.
410.673 Good cause for reopening a determination or decision.
410.674 Finality of suspension of benefit payments for entire taxable year because of earnings.
410.675 Time limitation for revising finding suspending benefit payments for entire taxable year because of earnings.
410.675a Late completion of timely investigation.
410.676 Notice of revision.
410.677 Effect of revised determination.
410.678 Time and place of requesting hearing on revised determination.

410.679 Finality of findings with respect to other claims for benefits based on the disability or death of a miner.
410.680 Imposition of reductions.
410.681 Change of ruling or legal precedent.
410.682 General applicability.
410.683 Certification of payment; determination or decision providing for payment.
410.683a [Reserved]
410.683b Transfer or assignment.
410.684 Representation of party; appointment of representative.
410.685 Qualifications of representative.
410.686 Authority of representative.
410.686a Proceedings before a State or Federal court.
410.686b Fee for services performed for an individual before the Social Security Administration.
410.686c Petition for approval of fee.
410.686d Payment of fees.
410.686e Services rendered for an individual in a proceeding before the Administration under part B of title IV of the Act.
410.687 Rules governing the representation and advising of claimants and parties.
410.687a Effective date.
410.688 Disqualification or suspension of an individual from acting as a representative in proceedings before SSA.
410.689 Notice of charges.
410.690 Withdrawal of charges.
410.691 Referral to the Deputy Commissioner for Programs and Policy, or his or her designee, for hearing and decision.
410.692 Hearing on charges.
410.693 Decision by hearing officer.
410.694 Right to request review of the hearing officer's decision.
410.695 Procedure before Appeals Council on review of hearing officer's decision.
410.696 Evidence admissible on review.
410.697 Decision by Appeals Council on review of hearing officer's decision.
410.698 Dismissal by Appeals Council.
410.699 Reinstatement after suspension or disqualification.
410.699a Penalties for fraud.

Subpart G—Rules for the Review of Denied and Pending Claims Under the Black Lung Benefits Reform Act (BLBRA) of 1977

410.700 Background.
410.701 Jurisdiction for determining entitlement under part B.
410.702 Definitions and terms.
410.703 Adjudicatory rules for determining entitlement to benefits.
410.704 Review procedures.
410.705 Duplicate claims.
410.706 Effect of Social Security Administration determination of entitlement.
410.707 Hearings and appeals.

Subpart A—Introduction, General Provisions, and Definitions

AUTHORITY: Secs. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), Secs. 3 (g) and (h), 402, 411, 412, 413, 414, 426(a), and 508, 83 Stat. 744; 30 U.S.C. 802 (g) and (h), 902, 921–924, 936(a), and 957. Sec. 410.120 also issued under sec. 1106, 53 Stat. 1398, as amended, 42 U.S.C. 1306.

§410.101 Introduction.

The regulations in this part 410 (Regulation No. 10 of the Social Security Administration) relate to the provisions of part B (Black Lung Benefits) of title IV of the Federal Coal Mine Health and Safety Act of 1969, as enacted December 30, 1969, as amended by the Black Lung Benefits Act of 1972, and as may hereafter be amended. The regulations in this part are divided into the following subparts according to subject content:

(a) This subpart A contains this introduction, general provisions, and provisions relating to definitions and the use of terms.

(b) Subpart B of this part relates to the requirements for entitlement, duration of entitlement, filing of claims, and evidence.

(c) Subpart C of this part describes the relationship and dependency required for widows, children, parents, brothers, and sisters, and relationship and dependency requirements which affect the benefit amounts of entitled miners and widows.

(d) Subpart D of this part provides standards for determining total disability and death due to pneumoconiosis.

(e) Subpart E of this part relates to payment of benefits, payment periods, benefit rates and their modification, representative payees, and overpayments and underpayments.

(f) Subpart F of this part relates to determinations of disability and other determinations, the procedures for administrative review, finality of decisions, and the representation of parties.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20635, Sept. 30, 1972]

§ 410.110 General definitions and use of terms.

For purposes of this part, except where the context clearly indicates otherwise, the following definitions apply:

(a) *The Act,* means the Federal Coal Mine Health and Safety Act of 1969 (Pub. L. 91–173), enacted December 30, 1969, as amended by the Black Lung Benefits Act of 1972 (Pub. L. 92–303), enacted May 19, 1972, and as may hereafter be amended.

(b) *Benefit* means the black lung benefit provided under part B of title IV of the Act to coal miners, to surviving widows of miners, to the surviving child or children of a miner, or of a widow of a miner, to the surviving dependent parent or parents of a miner, and to the surviving dependent brother(s) or sister(s) of a miner.

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

(d) *Administration* means the Social Security Administration (SSA).

(e) *Appeals Council* means the Appeals Council of the Social Security Administration or such member or members thereof as may be designated by the Chairman.

(f) *Administrative Law Judge* means an Administrative Law Judge (SSA).

(g) *Coal mine* means an area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations, and other property, real or personal, placed upon, under, or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite, or anthracite from its natural deposits in the earth by any means or method, and the work of preparing the coal so extracted, and includes custom coal preparation facilities.

(h) *Underground coal mine* means a coal mine in which the earth and other materials which lie above the natural deposit of coal (overburden) is not removed in mining. In addition to the natural deposits of coal in the earth, the underground mine includes all land, buildings and equipment appurtenant thereto.

(i) *Miner* or *coal miner* means any individual who is working or has worked as an employee in a coal mine, performing functions in extracting the coal or preparing the coal so extracted.

(j) *The Nation's coal mines* comprise all coal mines as defined in paragraph (h) of this section located in a State as defined in paragraph (l) of this section.

(k) *State* includes a State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and prior to January 3, 1959, and August 21, 1959, respectively, the Territories of Alaska and Hawaii.

(l) *Employee* means an individual in a legal relationship (between the person for whom he performs services and himself) of employer and employee under the usual common-law rules.

(1) Generally, such relationship exists when the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the means by which that result is accomplished; that is, an employee is subject to the will and control of the employer not only as to what shall be done but how it shall be done. In this connection, it is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if he has the right to do so. The right to discharge is also an important factor indicating that the person possessing that right is an employer. Other factors characteristic of an employer, but not necessarily present in every case, are the furnishing of tools and the furnishing of a place to work to the individual who performs the services. In general, if an individual is subject to the control or direction of another merely as to the result to be accomplished by the work and not as to the means and methods for accomplishing the result, he is an independent contractor. An individual performing services as an independent contractor is not as to such services an employee under the usual common-law rules.

(2) Whether the relationship of employer and employee exists under the

usual common-law rules will in doubtful cases be determined upon an examination of the particular facts of each case.

(m) The *Social Security Act* means the Social Security Act (49 Stat. 620) as amended from time to time.

(n) *Pneumoconiosis* means: (1) A chronic dust disease of the lung arising out of employment in the Nation's coal mines, and includes coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis, arising out of such employment.

For purposes of this subpart, the term also includes the following conditions that may be the basis for application of the statutory presumption of disability or death due to pneumoconiosis under the circumstances prescribed in section 411(c) of the Act:

(2) Any other chronic respiratory or pulmonary impairment when the conditions are met for the application of the presumption described in §410.414(b) or §410.454(b), and

(3) Any respirable disease when the conditions are met for the application of the presumption described in §410.462.

(o) A *workmen's compensation law* means a law providing for payment of compensation to an employee (and his dependents) for injury (including occupational disease) or death suffered in connection with his employment. A payment funded wholly out of general revenues and paid (without regard to insurance principles) solely on account of the financial need of the miner and his family, shall not be considered a payment under a workmen's compensation law.

(p) Masculine gender includes the feminine, and the singular includes the plural.

(q) *Beneficiary* means a miner or a surviving widow, child, parent, brother, or sister, who is entitled to a benefit as defined in paragraph (b) of this section.

[35 FR 5623, Apr. 7, 1970, as amended at 37 FR 20635, Sept. 30, 1972; 62 FR 38452, July 18, 1997]

§410.120 Disclosure of program information.

Disclosure of any file, record, report, or other paper, or any information obtained at any time by the Social Security Administration, or any officer or employee of that Administration, or any person, agency, or organization with whom the Administration has entered into an agreement to perform certain functions in the Administration of title IV of the Act, which in any way relates to, or is necessary to, or is used in, or in connection with, the administration of such title, shall be made in accordance with the regulations of the Administration contained in 20 CFR part 401, except that any such file, record, report, or other paper or information obtained in connection with the administration of the old-age, survivors, disability, or health insurance programs pursuant to titles II and XVIII of the Social Security Act, shall be disclosed only in accordance with Regulation No. 1 of the Social Security Administration, part 401 of this chapter.

[36 FR 23752, Dec. 14, 1971, as amended at 62 FR 38452, July 18, 1997]

§410.130 Periods of limitation ending on nonworkdays.

Where any provision of part B of title IV of the Act, or any provision of another law of the United States, relating to or changing the effect of part B, or any regulation of the Commissioner issued under part B, provides for a period within which an act is required to be done which affects eligibility for or the amount of any benefit or payment under this part or is necessary to establish or protect any right under this part, 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 section, the day on which a period ends shall include the final day of the extended period where such extension is authorized by law or by the Commissioner pursuant to law. Such extension of any period of limitation does not apply to periods during which benefits may be paid for months prior to the month a claim for such benefits is filed (see § 410.226).

[37 FR 20635, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

Subpart B—Requirements for Entitlement; Duration of Entitlement; Filing of Claims and Evidence

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), sec. 402, 411, 412, 413, 414, 426(a), and 508, 83 Stat. 792; 30 U.S.C. 902, 921–924, 936(a), 957.

SOURCE: 36 FR 23752, Dec. 14, 1971, unless otherwise noted.

§ 410.200 Types of benefits; general.

(a) Part B of title IV of the Act provides for the payment of periodic benefits:

(1) To a miner who is determined to be totally disabled due to pneumoconiosis; or

(2) To the widow or child of a miner who was entitled to benefits at the time of his death, who is determined to have been totally disabled due to pneumoconiosis at the time of his death, or whose death was due to pneumoconiosis; or

(3) To the child of a widow of a miner who was entitled to benefits at the time of her death; or

(4) To the surviving dependent parents, or the surviving dependent brothers or sisters, of a miner who is determined to have been entitled to benefits at the time of his death, or who was totally disabled due to pneumoconiosis at the time of his death, or whose death was due to pneumoconiosis.

(b) The following sections of this subpart set out the conditions of entitlement to benefits for a miner, a widow, child, parent, brother, or sister; describe the events which terminate or preclude entitlement to benefits and the procedures for filing a claim; and prescribe certain requirements as to evidence. Also see subpart C of this part for regulations relating to the relationship and dependency requirements applicable to claimants for benefits as a widow, child, parent, brother, or sister, and to beneficiaries with dependents.

[37 FR 20635, Sept. 30, 1972]

§ 410.201 Conditions of entitlement; miner.

An individual is entitled to benefits if such individual:

(a) Is a miner (see § 410.110(j)); and

(b) Is totally disabled due to pneumoconiosis (see subpart D of this part); and

(c) Has filed a claim for benefits in accordance with the provisions of §§ 410.220 through 410.234.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20635, Sept. 30, 1972]

§ 410.202 Duration of entitlement; miner.

(a) An individual is entitled to benefits as a miner for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 410.201 are satisfied.

(b) The last month for which such individual is entitled to such benefit is the month before the month:

(1) In which the miner dies (see, however, § 410.226); or

(2) In no part of which the miner is under a disability.

(c) A miner's entitlement to benefits under part B of title IV of the Act which is based on a claim which is filed (see § 410.227) after June 30, 1973, and before January 1, 1974, shall terminate on December 31, 1973, unless sooner terminated under paragraph (b) of this section.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20635, Sept. 30, 1972]

§ 410.210 Conditions of entitlement; widow or surviving divorced wife.

An individual is entitled to benefits if such individual:

(a) Is the widow (see § 410.320) or surviving divorced wife (see § 410.321) of a miner (see § 410.110(j));

(b) Is not married during her initial month of entitlement (or, for months prior to May 1972, had not remarried since the miner's death);

(c) Has filed a claim for benefits in accordance with the provisions of §§410.220 through 410.234;

(d) Was dependent on the miner at the pertinent time (see §410.360 or §410.361); and

(e) The deceased miner:

(1) Was entitled to benefits at the time of his death; or

(2) Died before January 1, 1974, and it is determined that he was totally disabled due to pneumoconiosis at the time of his death, or that his death was due to pneumoconiosis (see subpart D of this part).

[37 FR 20636, Sept. 30, 1972, as amended at 41 FR 4899, Feb. 3, 1976]

§410.211 Duration of entitlement; widow or surviving divorced wife.

(a) An individual is entitled to benefits as a widow, or as a surviving divorced wife, for each month beginning with the first month in which all of the conditions of entitlement prescribed in §410.210 are satisfied. If such individual remarries, payment of benefits ends with the month before the month of remarriage (see paragraph (b) of this section). Should the remarriage subsequently end, payment of benefits may be resumed beginning with the month after December 1973 in which the remarriage ends if the Social Security Administration receives notice in writing within 3 months of the end of such remarriage or within 3 months of February 3, 1976, whichever is later. Where such notice is not provided within the prescribed time period, resumption of payment will begin with the month the individual provides such notice to the Social Security Administration.

(b) The last month for which such individual is entitled to such benefit is the month before the month in which either of the following events first occurs:

(1) The widow or surviving divorced wife dies; or

(2) Where the individual has qualified as the widow of a miner under §410.320 (d), she ceases to so qualify, as provided therein.

(c) Although payment of benefits to a widow or surviving divorced wife ends with the month before the month in which she marries (see paragraph (a) of this section), her entitlement is not terminated by such marriage. However, but solely for purposes of entitlement of a child under §410.212(b), a widow is deemed not entitled to benefits in months for which she is not paid benefits because she is married.

[41 FR 4899, Feb. 3, 1976]

§410.212 Conditions of entitlement; child.

(a) An individual is entitled to benefits if such individual:

(1) Is the child or stepchild (see §410.330) of (i) a deceased miner (see §410.110(j)) or (ii) of the widow of a miner who was entitled to benefits at the time of her death (see §§410.210 and 410.211);

(2) Has filed a claim for benefits in accordance with the provisions of §§410.220 through 410.234;

(3) Meets the dependency requirements in §410.370;

(4) If a child of a miner, the deceased miner:

(i) Was entitled to benefits at the time of his death; or

(ii) Died before January 1, 1974, and his death is determined to have been due to pneumoconiosis (see subpart D of this part), or

(iii) Died before January 1, 1974, and it is determined that at the time of his death he was totally disabled by pneumoconiosis (see subpart D of this part).

(b) A child is not entitled to benefits for any month for which a widow of a miner is entitled to benefits, except that (for purposes of entitlement of a child under this section) a widow is deemed not entitled to benefits in months for which she is not paid benefits because she is married (see §410.211). Thus, a child may be entitled to benefits for months wherein such benefits are not payable to the widow because of marriage.

[37 FR 20636, Sept. 30, 1972, as amended at 41 FR 4900, Feb. 3, 1976]

§ 410.213 Duration of entitlement; child.

(a) An individual is entitled to benefits as a child for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 410.212 are satisfied.

(b) The last month for which such individual is entitled to or may be paid such benefit is the month before the month in which any one of the following events first occurs:

(1) The child dies;

(2) The child marries;

(3) The child attains age 18 and,

(i) Is not under a disability at that time, and

(ii) Is not a student (as defined in § 410.370) during any part of the month in which he attains age 18;

(4) If the child's entitlement is based on his status as a student, the earlier of:

(i) The first month during no part of which he is a student, or

(ii) The month in which he attains age 23 and is not under a disability at that time (but see § 410.370(c)(4) for an exception);

(5) If the child's entitlement is based on disability, the first month in no part of which such individual is under a disability;

(6) A widow's benefit payment, which was ended because of marriage, is resumed following termination of such marriage. (See § 410.211(a)). (In the month before the month in which a widow marries, payment of benefits to her ends and non-payment of such benefits continues for the duration of the marriage. Thereafter, if her remarriage ends, subject to the provisions of § 410.211 her benefit payments may be resumed. Should such widow again remarry or die, payment of benefits to such child, if he is otherwise entitled, will be resumed effective with the month of such remarriage or death. In such event no action by or on behalf of such child is required for resumption of payment.)

(c) A child whose entitlement to benefits terminated with the month before the month in which he attained age 18, or later, may thereafter (provided he is not married) again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month in which he files such application in or after such termination and in which he is a student and has not attained the age of 23.

[37 FR 20636, Sept. 30, 1972, as amended at 41 FR 4900, Feb. 3, 1976]

§ 410.214 Conditions of entitlement; parent, brother, or sister.

An individual is entitled to benefits if:

(a) Such individual:

(1) Is the parent, brother, or sister (see § 410.340) of a deceased miner (see § 410.110(j));

(2) Has filed a claim for benefits in accordance with the provisions of §§ 410.220 through 410.234;

(3) Was dependent on the miner at the pertinent time (see § 410.380); and

(4) Files proof of support before June 1, 1974, or within 2 years after the miner's death, whichever is later, or it is shown to the satisfaction of the Administration that there is good cause for failure to file such proof within such period (see § 410.216).

(b) In the case of a brother, he also:

(1) Is under 18 years of age; or

(2) Is 18 years of age or older and is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d) (see subpart P of part 404 of this chapter), which began:

(i) Before he attained age 22, however, no entitlement to brother's benefits may be established for any month before January 1973, based on a disability which began after attainment of age 18; or

(ii) In the case of a student, before he ceased to be a student (see § 410.370(c)); or

(3) Is a student (see § 410.370(c)); or

(4) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d) (see subpart P of part 404 of this chapter), at the time of the miner's death.

(c) In addition to the requirements set forth in paragraphs (a) and (b) of this section, the deceased miner:

(1) Was entitled to benefits at the time of his death; or

(2) Died before January 1, 1974, and his death is determined to have been due to pneumoconiosis (see subpart D of this part); or

(3) Died before January 1, 1974, and it is determined that at the time of his death he was totally disabled by pneumoconiosis (see subpart D of this part).

(d) Notwithstanding the provisions of paragraphs (a), (b), and (c) of this section:

(1) A parent is not entitled to benefits if the deceased miner was survived by a widow or child at the time of his death, and

(2) A brother or sister is not entitled to benefits if the deceased miner was survived by a widow, child, or parent at the time of his death.

[37 FR 20636, Sept. 30, 1972, as amended at 41 FR 7091, Feb. 17, 1976]

§410.215 Duration of entitlement; parent, brother, or sister.

(a) parent, brother, or sister is entitled to benefits beginning with the month all the conditions of entitlement described in §410.214 are met.

(b) The last month for which such parent is entitled to benefits is the month before the month in which the parent dies.

(c) The last month for which such sister is entitled to benefits is the month before the month in which any of the following events occurs:

(1) She dies;

(2)(i) She marries or remarries; or

(ii) If already married, she receives support in any amount from her spouse.

(d) The last month for which such brother is entitled to benefits is the month before the month in which any of the following events first occurs:

(1) He dies;

(2)(i) He marries or remarries; or

(ii) If already married, he receives support in any amount from his spouse;

(3) He attains age 18 and,

(i) Is not under a disability at that time, and

(ii) Is not a student (see §410.370(c)) during any part of the month in which he attains age 18;

(4) If his entitlement is based on his status as a student, the earlier of:

(i) The first month during no part of which he is a student; or

(ii) The month in which he attains age 23 and is not under a disability at that time;

(5) If his entitlement is based on disability, the first month in no part of which such individual is under a disability.

[37 FR 20636, Sept. 30, 1972]

§410.216 "Good cause" for delayed filing of proof of support.

(a) *What constitutes ''good cause.'' Good cause* may be found for failure to file proof of support within the 2-year period where the parent, brother, or sister establishes to the satisfaction of the Administration that such failure to file was due to:

(1) Circumstances beyond the individual's control, such as extended illness, mental or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished the individual by the Administration; or

(3) Efforts by the individual to secure supporting evidence without a realization that such evidence could be submitted after filing proof of support; or

(4) Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely the proof of support.

(b) *What does not constitute ''good cause.'' Good cause* for failure to file timely such proof of support does not exist when there is evidence of record in the Administration that the individual was informed that he should file within the initial 2-year period and he failed to do so through negligence or intent not to file.

[37 FR 20637, Sept. 30, 1972]

§410.219 Filing a claim under State workmen's compensation law; when filing such claim shall be considered futile.

(a) A claimant for benefits under this part must file a claim under the applicable State workmen's compensation law prior to a final decision on his claim for benefits under this part (see §410.227(c)) except where the filing of a claim under such applicable State workmen's compensation law would clearly be futile.

(b) The Administration shall determine that the filing of such a claim would clearly be futile when:

(1) The period within which such a claim may be filed under such law has expired; or

(2) Pneumoconiosis as defined in § 410.110(o) is not compensable under such law; or

(3) The maximum amount of compensation or the maximum number of compensation payments allowable under such law has already been paid; or

(4) The claimant does not meet one or more conditions of eligibility for workmen's compensation payments under applicable State law; or

(5) In any other situation the claimant establishes to the satisfaction of the Administration that the filing of a claim on account of pneumoconiosis would result as a matter of law in a denial of his claim for compensation under such law.

(c) To be considered to have complied with the statutory requirement for filing a claim under the applicable State workmen's compensation law, a claimant for benefits under this part must diligently prosecute such State claim.

(d) Where, but for the failure to file a claim under the applicable State workmen's compensation law, an individual's claim for benefits under this part would be allowed, the Administration shall notify the individual in writing of the need to file such State claim as a prerequisite to such allowance. Such claim, when filed within 30 days of the date such notice is mailed to the individual, will be considered to have been filed timely.

(e) Where, on the other hand, a claim has not been filed under the applicable State workmen's compensation law, and the Administration determines that a claim for benefits under this part would be disallowed even if such a State claim were filed, the Administration shall make such determination as may be necessary for the adjudication of the individual's claim for benefits under this part pursuant to § 410.610.

[36 FR 23752, Dec. 14, 1971; 36 FR 24214, Dec. 22, 1971. Redesignated at 37 FR 20636, Sept. 30, 1972]

§ 410.220 Claim for benefits; definitions.

For purposes of this part:

(a) *Claim defined.* The term *claim* means a writing asserting a right to benefits by an individual, or by a proper party on his behalf as defined in § 410.222, which writing is filed with the Administration in accordance with the regulations in this subpart.

(b) *Application defined.* The term *application* refers only to a writing on a form prescribed in § 410.221.

(c) *Claimant defined.* The term *claimant* refers to the individual who has filed a claim for benefits on his own behalf, or on whose behalf a proper party as defined in § 410.222 has filed a claim.

(d) *Applicant defined.* The term *applicant* refers to the individual who has filed an application on his own behalf, or on behalf of another, for benefits.

(e) *Execution of claim defined.* The term *to execute a claim* means to complete and sign an application (but, for an exception, see § 410.234). Irrespective of who may have prepared or completed the application, it is considered to have been executed by or on behalf of the claimant when it is signed by him or by an individual authorized to do so on his behalf (see § 410.222).

(f) *Provisions with respect to claims applicable with respect to requests.* The provisions of §§ 410.222 through 410.234 (relating to the preparation, execution, or filing of a claim for benefits) are applicable to the preparation, execution, and filing of a written request required under this part, e.g., a request to be selected as representative payee (see § 410.581 et seq.), a request for separate payment of an augmentation (see § 410.511), a request for reconsideration (see § 410.622), etc. In such cases, the term *claimant* as used therein refers to the individual filing the request on his own behalf or the individual on whose behalf such request is filed.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20637, Sept. 30, 1972]

§ 410.221 Prescribed application and request forms.

(a) Claims shall be made as provided in this subpart on such application forms and in accordance with such instructions (provided thereon or attached thereto) as are prescribed by the Administration.

(b) The application forms used by the public to file claims for benefits under

part B of title IV of the Act are SSA–46 (application for benefits under the Federal Coal Mine Health and Safety Act of 1969 (coal miner's claim of total disability)), SSA–47 (application for benefits under the Federal Coal Mine Health and Safety Act of 1969 (widow's claim)), SSA–48 (application for benefits under the Black Lung Benefits Act of 1972 (child's claim)), and SSA–49 (application for benefits under the Black Lung Act of 1972 (parent's, brother's, or sister's claim)).

(c) The form used by an individual to request that such individual be selected as a representative payee or by a dependent to request that payment be certified to him separately is SSA–50 (Request to be Selected as Payee).

(d) For further information about some of the forms used in the administration of part B of title IV of the Act, see §§ 422.505(b), 422.515, 422.525, and 422.527 of this chapter.

[37 FR 20637, Sept. 30, 1972]

§ 410.222 Execution of a claim.

The Administration determines who is the proper party to execute a claim in accordance with the following rules:

(a) If the claimant has attained the age of 18, is mentally competent, and is physically able to execute the claim, the claim shall be executed by him. Where, however, paragraph (d) of this section applies, the claim may also be executed by the claimant's legal guardian, committee, or other representative.

(b) If the claimant is between the ages of 16 and 18, is mentally competent, has no legally appointed guardian, committee, or other representative, and is not in the care of any person, such claimant may execute the claim upon filing a statement on the prescribed form indicating capacity to act on his own behalf.

(c) If the claimant is mentally competent but has not attained age 18 and is in the care of a person, the claim may be executed by such person.

(d) If the claimant (regardless of his age) has a legally appointed guardian, committee, or other representative, the claim may be executed by such guardian committee, or representative.

(e) If the claimant (regardless of his age) is mentally incompetent or is physically unable to execute the claim, it may be executed by the person who has the claimant in his care or by a legally appointed guardian, committee, or other representative.

(f) Where the claimant is in the care of an institution and is not mentally competent or physically able to execute a claim, the manager or principal officer of such institution may execute the claim.

(g) For good cause shown, the Administration may accept a claim executed by a person other than one described in paragraph (a), (b), (c), (d), (e), or (f) of this section.

[37 FR 20637, Sept. 30, 1972]

§ 410.223 Evidence of authority to execute a claim on behalf of another.

Where the claim is executed by a person other than the claimant, such person shall, at the time of filing the claim or within a reasonable time thereafter, file evidence of his authority to execute the claim on behalf of such claimant in accordance with the following rules:

(a) If the person executing the claim is the legally appointed guardian, committee, or other legal representative of such claimant, the evidence shall be a certificate executed by the proper official of the court of appointment.

(b) If the person executing the claim is not such a legal representative, the evidence shall be a statement describing his relationship to the claimant, the extent to which he has the care of such claimant, or his position as an officer of the institution of which the claimant is an inmate. The Administration may, at any time, require additional evidence to establish the authority of any such person.

§ 410.224 Claimant must be alive when claim is filed.

For a claim to be effective, the claimant must be alive at the time a properly executed claim (see § 410.222) is filed with the Administration (see § 410.227). (See §§ 410.229 and 410.230 concerning the filing of a prescribed application form after submittal of a written statement.)

§ 410.226 Periods for which claims are effective.

(a) *Application effective for entire month of filing.* Benefits are payable for full calendar months. If the claimant meets all the requirements for entitlement to benefits in the same calendar month in which his application is filed, the application will be effective for the whole month. If a miner dies in the first month for which he meets all the requirements for entitlement to benefits, he will, notwithstanding the provisions of § 410.202(b), be considered to be entitled to benefits for that month.

(b) *Prospective life of claims.* A claim which is filed before the claimant meets all the requirements for entitlement to such benefits will be deemed a valid claim if the claimant meets such requirements of entitlement (1) before the Administration makes a final decision on such claim or (2) if the claimant has timely requested judicial review of such final decision before such review is completed. If the claimant first meets the requirements for entitlement to benefits in a month after the month of actual filing but before a final administrative or judicial decision is rendered on his claim, his claim will be deemed to have been effectively filed in such first month of entitlement.

(c) *Retroactive life of claims.* Except in the case of a claim for benefits as a surviving child (see § 410.212) a claim for benefits has no retroactive effect. (See, however, § 410.230.) Generally, a claim for benefits for a surviving child is effective (depending on the first month of eligibility) for up to 12 months preceding the month in which such claim is filed. However, if such claim is filed before December 1972, such claim may be effective retroactively (depending on the first month of eligibility) to December 1969.

[37 FR 20637, Sept. 30, 1972]

§ 410.227 When a claim is considered to have been filed; time and place of filing.

(a) *Date of receipt.* Except as otherwise provided in this part, a claim is considered to have been filed only as of the date it is received at an office of the Administration or by an employee of the Administration who is authorized to receive such claims.

(b) *Date of mailing.* If the claim is deposited in and transmitted by the U.S. mail and the fixing of the date of delivery as the date of filing would result in a loss or impairment of benefit rights, it will be considered to have been filed as of the date of mailing. The date appearing on the postmark (when available and legible) shall be prima facie evidence of the date of mailing. If there is no postmark or it is not legible, other evidence may be used to establish the mailing date.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20637, Sept. 30, 1972]

§ 410.228 Requests and notices to be in writing.

Except as otherwise provided in this part, any request to the Administration for a determination or a decision relating to a person's right to benefits, the withdrawal of a claim, the cancellation of a request for such withdrawal, or any notice provided for pursuant to the regulations in this part 410, shall be in writing and shall be signed by the person authorized to execute a claim under § 410.222.

§ 410.229 When written statement is considered a claim; general.

(a) *Written statement filed by claimant on his own behalf.* Where an individual files a written statement with the Administration (see § 410.227) which indicates an intention to claim benefits, and such statement bears his signature or his mark properly witnessed, the filing of such written statement, unless otherwise indicated by the regulations in this part, shall be considered to be the filing of a claim for benefits: *Provided*, That:

(1) The claimant or a proper party on his behalf (see § 410.222) executes a prescribed application form (see § 410.221) that is filed with the Administration during the claimant's lifetime and within the period prescribed in paragraph (c)(1) of this section; or

(2) In the case of a claimant who dies prior to the filing of such prescribed application form within the period prescribed in paragraph (c)(1) of this section, a prescribed application form is filed with the Administration within

the period prescribed in paragraph (c)(2) of this section by a party acting on behalf of the deceased claimant's estate.

(b) *Written statement filed by individual on behalf of another.* A written statement filed by an individual which indicates an intention to claim benefits on behalf of another person shall, unless otherwise indicated thereon, be considered to be the filing of a claim for such purposes: *Provided,* That:

(1) The written statement bears the signature (or mark properly witnessed) of the individual filing the statement; and

(2) The individual filing the statement is the spouse of the claimant on whose behalf the statement is being filed, or a proper party to execute a claim on behalf of a claimant as determined by §410.222; and

(3) Except as specified in §410.230, a prescribed application form (see §410.221) is executed and filed in accordance with the provisions of paragraph (a) (1) or (2) of this section.

(c) *Period within which prescribed application form must be filed.* After the Administration has received from an individual a written statement as described in paragraph (a) or (b) of this section:

(1) Notice in writing shall be sent to the claimant or to the individual who submitted the written statement on his behalf, stating that an initial determination will be made with respect to such written statement if a prescribed application form executed by the claimant or by a proper party on his behalf (see §410.222), is filed with the Administration within 6 months from the date of such notice; or

(2) If the Administration is notified that the death of such claimant occurred before the mailing of the notice described in paragraph (c)(1) of this section, or within the 6–month period following the mailing of such notice but before the filing of a prescribed application form by or on behalf of such individual, notification in writing shall be sent to a person acting on behalf of his estate, or to the deceased's last known address. Such notification will include information that an initial determination with respect to such written statement will be made only if a prescribed application form is filed within 6 months from the date of such notification.

(3) If, after the notice as described in this paragraph (c) has been sent, a prescribed application form is not filed (in accordance with the provisions of paragraph (a) or (b) of this section) within the applicable period prescribed in paragraph (c)(1) or (c)(2) of this section, it will be deemed that the filing of the written statement to which such notice refers is not to be considered the filing of a claim for the purposes set forth in paragraphs (a) and (b) of this section.

[36 FR 23752, Dec. 14, 1971, as amended at 39 FR 41525, Nov. 29, 1974]

§410.230 Written statement filed by or for a miner on behalf of a member of his family.

Notwithstanding the provisions of §410.229, the Social Security Administration will take no action with respect to a written statement filed by or for a miner on behalf of a member of his family until such miner's death. At such time, the provisions of §410.229 shall apply as if such miner's claim on behalf of a member of his family had been filed on the day of the miner's death. However, for purposes of paying benefits to an otherwise entitled survivor of a miner, such written statement will be considered to be a valid claim for benefits (see §§410.210(c) and 410.212(a)(2)) where such member of his family qualified as a dependent for purposes of augmentation of the miner's benefits prior to his death. In such case the member of his family is not required to file a prescribed application form (see §410.221) with the Social Security Administration (see §410.229(b)). Nevertheless, the survivor beneficiary may be required to furnish supplemental information within 6 months of notification to do so. If such beneficiary fails to furnish the information requested within 6 months of notice to do so, benefits may be suspended, after notice of such proposed action and opportunity to be heard is provided the beneficiary. A subsequent determination to suspend benefits shall be an initial determination (see §410.610).

[39 FR 41525, Nov. 29, 1974]

§ 410.231 Time limits for filing claims.

(a) A claim by or on behalf of a miner must be filed on or before December 31, 1973, and when so filed, is a claim for benefits under part B of title IV of the Act. (See § 410.227 for when a claim is considered to have been filed. See also § 410.202(c) for the duration of entitlement to benefits of a miner based on a claim for such benefits which is filed after June 30, 1973, and before January 1, 1974.)

(b) In the case of a miner who was entitled to benefits for the month before the month of his death, or died in the first month for which he met all the requirements for entitlement (see § 410.226), a claim for benefits by or on behalf of the widow, child, parent, brother, or sister of a miner must be filed by December 31, 1973, or within 6 months after the miner's death, whichever is later. When so filed, it constitutes a claim for benefits under part B of title IV of the Act.

(c) In the case of a miner who was not entitled to benefits for the month before the month of his death, and whose death occurred prior to January 1, 1974, a claim for benefits by or on behalf of the widow, child, parent, brother, or sister of a miner must be filed by December 31, 1973, or, in the case of the death of a miner occurring after June 30, 1973, and before January 1, 1974, within 6 months of such miner's death. When so filed, it constitutes a claim for benefits under part B of title IV of the Act.

(d) Notwithstanding the provisions of paragraphs (b) and (c) of this section, if a widow established entitlement to benefits under this part (see § 410.210), a claim by or on behalf of a surviving child of a miner or of such widow, must be filed within 6 months after the death of such miner or of such widow, or by December 31, 1973, whichever is the later.

[37 FR 20637, Sept. 30, 1972]

§ 410.232 Withdrawal of a claim.

(a) *Before adjudication of claim.* A claimant (or an individual who is authorized to execute a claim on his behalf under § 410.222), may withdraw his previously filed claim provided that:

(1) He files a written request for withdrawal.

(2) The claimant is alive at the time the request for withdrawal is filed,

(3) The Administration approves the request for withdrawal, and

(4) The request for withdrawal is filed on or before the date the Administration makes a determination on the claim.

(b) *After adjudication of claim.* A claim for benefits may be withdrawn by a written request filed after the date the Administration makes a determination on the claim provided that:

(1) The conditions enumerated in paragraphs (a) (1) through (3) of this section are met; and

(2) There is repayment of the amount of benefits previously paid because of the claim that is being withdrawn or it can be established to the satisfaction of the Administration that repayment of any such amount is assured.

(c) *Effect of withdrawal of claim.* Where a request for withdrawal of a claim is filed and such request for withdrawal is approved by the Administration, such claim will be deemed not to have been filed. After the withdrawal (whether made before or after the date the Administration makes a determination) further action will be taken by the Administration only upon the filing of a new claim, except as provided in § 410.233.

§ 410.233 Cancellation of a request for withdrawal.

Before or after a written request for withdrawal has been approved by the Administration, the claimant (or a person who is authorized under § 410.222 to execute a claim on his behalf) may request that the ''request for withdrawal'' be canceled and that the withdrawn claim be reinstated. Such request for cancellation must be in writing and must be filed, in a case where the requested withdrawal was approved by the Administration, no later than 60 days after such approval. The claimant must be alive at the time the request for cancellation of the ''request for withdrawal'' is filed with the Administration.

§410.234 Interim provisions.

(a) Notwithstanding any other provision of this subpart, a written request for benefits which is filed before January 31, 1972, and which meets the requirements of this subpart except for the filing of a prescribed application form, shall be considered a claim for benefits. Nevertheless, where a prescribed application form has not been filed, the Administration may require that such a form be completed and filed before adjudicating the claim. (See §410.240(a).)

(b) Notwithstanding any other provision of this part, where (1) a request has been made before the effective date of this regulation that a claim for benefits be withdrawn and (2) such request has been approved (see §410.232), such claim may nevertheless be reinstated and adjudicated under the provisions of the Black Lung Benefits Act of 1972 (Pub. L. 92–303).

[37 FR 20638, Sept. 30, 1972]

§410.240 Evidence.

(a) *Evidence of eligibility.* A claimant for benefits shall submit such evidence of eligibility as is specified in this section. The Administration may at any time require additional evidence to be submitted with regard to entitlement or the right to receive payment.

(b) *Insufficient evidence of eligibility.* Whenever a claimant for benefits has submitted no evidence or insufficient evidence of eligibility, the Administration will inform the claimant what evidence is necessary for a determination of eligibility and will request him to submit such evidence within a specified reasonable time which may be extended for a further reasonable time upon the claimant's request.

(c) *Reports by beneficiary; evidence of nonoccurrence of termination, suspension, or reduction event.* Any individual entitled to a benefit who is aware of any circumstance which, under the provisions of this part could affect his entitlement to benefits, his eligibility for payment, or the amount of his benefit, or result in the termination, suspension, or reduction of his benefit, shall promptly report such circumstance to the Administration. The Administration may at any time require an individual receiving, or claiming that he is entitled to receive, a benefit, either on behalf of himself or on behalf of another, to submit a written statement giving pertinent information bearing upon the issue of whether or not an event has occurred which would cause such benefit to be terminated, or which would subject such benefit to reductions or suspension under the provisions of the Act. The failure on the part of such individual to submit any such report or statement, properly executed, to the Administration, shall subject such benefit to reductions, suspension, or termination, as the case may be.

(d) *Place and manner of submitting evidence.* Evidence in support of a claim shall be filed at an office of the Administration or with an employee of the Administration authorized to receive such evidence at a place other than such office. Such evidence may be submitted as part of a prescribed application form if the form provides for its inclusion, or it may be submitted in addition to such prescribed form and in the manner indicated in this section.

(e) *Certification of evidence by authorized individual.* In cases where a copy of a record, document, or other evidence, or an excerpt of information therefrom, is acceptable as evidence in lieu of the original, such copy or excerpt shall, except as may otherwise clearly be indicated thereon, be certified as a true and exact copy or excerpt by the official custodian of any such record or by an employee of the Administration authorized to make certifications of any such evidence.

(f) *Evidence of total disability or death due to pneumoconiosis.* For evidence requirements to support allegations of total disability or death due to pneumoconiosis; for the effect of the failure or refusal of an individual to present himself for an examination or test in connection with the alleged disability, or to submit evidence of disability; and for evidence as to the cessation of disability, see subpart D of this part 410.

(g) *Evidence of matters other than total disability or death due to pneumoconiosis.* With respect to the following matters, evidence shall be submitted in accordance with the provisions of Regulations No. 4 (part 404 of this chapter) cited

hereinafter, as if the claim for benefits under the Act were an application for benefits under section 202 of the Social Security Act. Evidence as to:

(1) *Age:* §§ 404.715 through 404.716 of this part;

(2) *Death:* §§ 404.720 through 404.722 of this part;

(3) *Marriage and termination of marriage:* §§ 404.723 through 404.728 of this part;

(4) *Relationship of parent and child:* §§ 404.730 through 404.750 of this part;

(5) *Domicile:* § 404.770 of this part;

(6) *Living with or member of the same household:* § 404.760 of this part.

(h) *Reimbursement for reasonable expenses in obtaining medical evidence.* Claimants for benefits under this part shall be reimbursed promptly for reasonable medical expenses incurred by them for services from medical sources of their choice, in establishing their claims, including the reasonable and necessary cost of travel incident thereto. A medical expense generally is not ''reasonable'' when the medical evidence for which the expense was incurred is of no value in the adjudication of a claim. Medical evidence will then be considered to be of ''no value'' when, for instance, it is wholly duplicative or when it is wholly extraneous to the medical issue of whether the claimant is disabled or died due to pneumoconiosis. In order to minimize inconvenience and possible expense to the claimant, he should not generally incur any medical expense for which he intends to claim reimbursement without first contacting the district office to determine what types of evidence not already available to the Administration may be useful in adjudicating his claim, what types of medical evidence may be reimbursable, and what would constitute a ''reasonable medical expense'' in a given case. However, a claimant's failure to contact the Administration before the expense is incurred will not preclude the Administration from later approving reimbursal for any reasonable medical expense. Where a reasonable expense for medical evidence is ascertained, the Administration may authorize direct payment to the provider of such evidence.

[36 FR 23752, Dec. 14, 1971, as amended at 37 FR 20638, Sept. 30, 1972; 65 FR 16814, Mar. 30, 2000]

§ 410.250 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

An individual who has been finally convicted by a court of competent jurisdiction of the felonious and intentional homicide of a miner or of a widow shall not be entitled to receive any benefits payable because of the death of such miner or widow, and such felon shall be considered nonexistent in determining the entitlement to benefits of other individuals with respect to such miner or widow.

[37 FR 20638, Sept. 30, 1972]

Subpart C—Relationship and Dependency

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), secs. 402, 412(a), 426(a), and 508, 83 Stat. 792; 30 U.S.C. 902, 922(a), 936, and 957.

§ 410.300 Relationship and dependency; general.

(a) In order to establish entitlement to benefits, a widow, child, parent, brother, or sister must meet relationship and dependency requirements with respect to the miner or widow, as applicable, prescribed by or pursuant to the Act.

(b) In order for an entitled miner or widow to qualify for augmented benefits because of one or more dependents (see § 410.510(c)), such dependents must meet relationship and dependency requirements with respect to such beneficiary prescribed by or pursuant to the Act.

(c) References in §§ 410.310(c), 410.320(c), 410.330(d), and 410.340, to the ''same right to share in the intestate personal property'' of a deceased miner (or widow), refer to the right of an individual to share in such distribution in his own right and not by right of representation.

[37 FR 20638, Sept. 30, 1972]

§410.310 Determination of relationship; wife.

An individual will be considered to be the wife of a miner if:

(a) The courts of the State in which such miner is domiciled (see §410.392) would find that such individual and the miner were validly married; or

(b) The courts of the State in which such miner is domiciled (see §410.392) would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual is the miner's wife; or

(c) Under State law, such individual has the same right she would have if she were the wife to share in the miner's intestate personal property; or

(d)(1) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which, but for a legal impediment (see §410.391), would have been a valid marriage. However, such purported marriage shall not be considered a valid marriage if such individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household (see §410.393) in the month in which there is filed a request that the miner's benefits be augmented because such individual qualifies as his wife (see §410.510(c)). The provisions of this paragraph shall not apply, however, if the miner's benefits are or have been augmented under §410.510(c) because another person qualifies or has qualified as his wife and such other person is, or is considered to be, the wife of such miner under paragraph (a), (b), or (c) of this section at the time such request is filed.

(2) The qualification for augmentation purposes of an individual who would not be considered to be the wife of such miner but for this paragraph (d), shall end with the month before the month in which (i) the Administration determines that the benefits of the miner should be augmented on account of another person, if such other person is (or is considered to be) the wife of such miner under paragraph (a), (b), or (c) of this section, or (ii) if the individual who previously qualified as a wife for purposes of §410.510(c), entered into a marriage valid without regard to this paragraph, with a person other than such miner.

[36 FR 23756, Dec. 14, 1971, as amended at 37 FR 20638, Sept. 30, 1972]

§410.311 Determination of relationship; divorced wife.

An individual will be considered to be the divorced wife of a miner if her marriage to such miner has been terminated by a final divorce on or after the 20th anniversary of the marriage: *Provided,* That if she was married to and divorced from him more than once, she was married to him in each calendar year of the period beginning 20 years immediately before the date on which any divorce became final and ending with the year in which that divorce became final.

[37 FR 20638, Sept. 30, 1972]

§410.320 Determination of relationship; widow.

An individual will be considered to be the widow of a miner if:

(a) The courts of the State in which such miner was domiciled (see §410.392) at the time of his death would find that the individual and the miner were validly married; or

(b) The courts of the State in which such miner was domiciled (see §410.392) at the time of his death would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual was the miner's widow; or

(c) Under State law, such individual has the same right she would have as if she were the miner's widow to share in the miner's intestate personal property; or

(d) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which, but for a legal impediment (see §410.391) would have been a valid marriage. However, such purported marriage shall not be considered a valid marriage if such individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household (see §410.393) at the time of

the miner's death. The provisions of this paragraph shall not apply if another person is or has been entitled to benefits as the widow of the miner and such other person is, or is considered to be, the widow of such miner under paragraph (a), (b), or (c) of this section at the time such individual files her claim for benefits.

[36 FR 23756, Dec. 14, 1971, as amended at 37 FR 20638, Sept. 30, 1972]

§ 410.321 Determination of relationship; surviving divorced wife.

An individual will be considered to be the surviving divorced wife of a deceased miner if her marriage to such miner had been terminated by a final divorce on or after the 20th anniversary of the marriage: *Provided*, That, if she was married to and divorced from him more than once, she was married to him in each calendar year of the period beginning 20 years immediately before the date on which any divorce became final and ending with the year in which that divorce became final.

[37 FR 20639, Sept. 30, 1972]

§ 410.330 Determination of relationship; child.

As used in this section, the term *beneficiary* means only a widow entitled to benefits at the time of her death (see § 410.211), or a miner, except where there is a specific reference to the ''father'' only, in which case it means only a miner. An individual will be considered to be the child of a beneficiary if:

(a) The courts of the State in which such beneficiary is domiciled (see § 410.392) would find, under the law they would apply in determining the devolution of the beneficiary's intestate personal property, that the individual is the beneficiary's child; or

(b) Such individual is the legally adopted child of such beneficiary; or

(c) Such individual is the stepchild of such beneficiary by reason of a valid marriage of his parent or adopting parent to such beneficiary; or

(d) Such individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) Such individual is the natural son or daughter of a beneficiary but does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if the beneficiary and the mother or the father, as the case may be, of such individual went through a marriage ceremony resulting in a purported marriage between them which, but for a legal impediment (see § 410.391), would have been a valid marriage.

(f) Such individual is the natural son or daughter of a beneficiary but does not have the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if:

(1) Such beneficiary, prior to his entitlement to benefits, has acknowledged in writing that the individual is his son or daughter, or has been decreed by a court to be the father of the individual, or he has been ordered by a court to contribute to the support of the individual (see § 410.395(c)) because the individual is his son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father of the individual and was living with or contributing to the support of the individual at the time such beneficiary became entitled to benefits.

(g) Such individual is the natural son or daughter of a beneficiary but does not have the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of such beneficiary for months no earlier than June 1974, if:

(1) Such beneficiary has acknowledged in writing that the individual is his son or daughter, or has been decreed by a court to be the father of the

individual, or he has been ordered by a court to contribute to the support of the individual (see §410.395(c)) because the individual is his son or daughter; and in the case of a deceased individual such acknowledgement, court decree, or court order was made before the death of such beneficiary; or

(2) Such beneficiary is shown by satisfactory evidence to be the father of the individual and was living with or contributing to the support of the individual at the time such request for benefits is made.

[36 FR 23756, Dec. 14, 1971, as amended at 37 FR 20639, Sept. 30, 1972; 41 FR 33550, Aug. 10, 1976]

§410.340 Determination of relationship; parent, brother, or sister.

An individual will be considered to be the parent, brother, or sister of a miner if the courts of the State in which such miner was domiciled (see §410.392) at the time of his death would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual is the miner's parent, brother, or sister. Where, under such law, the individual does not bear the relationship to the miner of parent, brother, or sister, but would, under State law, have the same status (i.e., right to share in the miner's intestate personal property) as a parent, brother, or sister, the individual will be deemed to be such. An individual will be considered to be the parent, brother, or sister of a miner if the individual is the stepparent, stepbrother, stepsister, half brother, or half sister of the miner, or is the parent, brother, or sister of the miner by adoption.

[37 FR 20639, Sept. 30, 1972]

§410.350 Determination of dependency; wife.

An individual who is the miner's wife (see §410.310) will be determined to be dependent upon the miner if:

(a) She is a member of the same household as the miner (see §410.393); or

(b) She is receiving regular contributions from the miner for her support (see §410.395(c)); or

(c) The miner has been ordered by a court to contribute to her support (see §410.395(e)); or

(d) She is the natural mother of the son or daughter of the miner; or

(e) She was married to the miner (see §410.310) for a period of not less than 1 year.

[37 FR 20639, Sept. 30, 1972]

§410.351 Determination of dependency; divorced wife.

An individual who is the miner's divorced wife (see §410.311) will be determined to be dependent upon the miner if:

(a) She is receiving at least one-half of her support from the miner (see §410.395(g)); or

(b) She is receiving substantial contributions from the miner pursuant to a written agreement (see §410.395 (c) and (f)); or

(c) There is in effect a court order for substantial contributions to her support to be furnished by such miner (see §410.395 (c) and (e)).

[37 FR 20639, Sept. 30, 1972]

§410.360 Determination of dependency; widow.

(a) *General.* An individual who is the miner's widow (see §410.320) will be determined to have been dependent on the miner if, at the time of the miner's death:

(1) She was living with the miner (see §410.393); or

(2) She was dependent upon the miner for support or the miner has been ordered by a court to contribute to her support (see §410.395); or

(3) She was living apart from the miner because of his desertion or other reasonable cause; or

(4) She is the natural mother of his son or daughter; or

(5) She had legally adopted his son or daughter while she was married to him and while such son or daughter was under the age of 18; or

(6) He had legally adopted her son or daughter while she was married to him and while such son or daughter was under the age of 18; or

(7) She was married to him at the time both of them legally adopted a child under the age of 18; or

(8) She was married to him for a period of not less than 9 months immediately prior to the day on which he died (but see paragraph (b) of this section).

(b) *Waiver of 9-month requirement*—(1) *General.* Except as provided in paragraph (b)(3) of this section, the requirement in paragraph (a)(8) of this section that the surviving spouse of a miner must have been married to him for a period of not less than 9 months immediately prior to the day on which he died in order to qualify as such miner's widow, shall be deemed to be satisfied where such miner dies within the applicable 9-month period, if his death:

(i) Is accidental (as defined in paragraph (b)(2) of this section), or

(ii) Occurs in line of duty while he is a member of a uniformed service serving on active duty (as defined in § 404.1013 (f) (2) and (3) of this chapter), and such surviving spouse was married to such miner for a period of not less than 3 months immediately prior to the day on which he died.

(2) *Accidental death.* For purposes of paragraph (b)(1)(i) of this section, the death of a miner is accidental if such individual receives bodily injuries solely through violent, external, and accidental means and, as a direct result of the bodily injuries and independently of all other causes, loses his life not later than 3 months after the day on which he receives such bodily injuries. The term *accident* means an event that was unpremeditated and unforeseen from the standpoint of the deceased individual. To determine whether the death of an individual did, in fact, result from an accident the Administration will consider all the circumstances surrounding the casualty. An intentional and voluntary suicide will not be considered to be death by accident; however, suicide by an individual who is so insane as to be incapable of acting intentionally and voluntarily will be considered to be death by accident. In no event will the death of an individual resulting from violent and external causes be considered a suicide unless there is direct proof that the fatal injury was self-inflicted.

(3) *Applicability.* The provisions of this paragraph shall not apply if the Administration determines that at the time of the marriage involved, the miner could not reasonably have been expected to live for 9 months.

[37 FR 20639, Sept. 30, 1972]

§ 410.361 Determination of dependency; surviving divorced wife.

An individual who is the miner's surviving divorced wife (see § 410.321) will be determined to have been dependent on the miner if, for the month preceding the month in which the miner died:

(a) She was receiving at least one-half of her support from the miner (see § 410.395(g)); or

(b) She was receiving substantial contributions from the miner pursuant to a written agreement (see § 410.395 (c) and (f)); or

(c) There was in effect a court order for substantial contributions to her support to be furnished by such miner (see § 410.395 (c) and (e)).

[37 FR 20639, Sept. 30, 1972]

§ 410.370 Determination of dependency; child.

For purposes of augmenting the benefits of a miner or widow (see § 410.510 (c)), the term *beneficiary* as used in this section means only a miner or widow entitled to benefits (see §§ 410.201 and 410.210); or, for purposes of an individual's entitlement to benefits as a surviving child (see § 410.212), the term *beneficiary* as used in this section means only a deceased miner (see § 410.200) or a deceased widow who was entitled to benefits for the month prior to the month of her death (see §§ 410.210 and 410.211). An individual who is the beneficiary's child (see § 410.330) will, as applicable, be determined to be, or to have been, dependent on the beneficiary, if the child:

(a) Is unmarried; and

(b)(1) Is under 18 years of age; or

(2) Is 18 years of age or older and is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d) (see subpart P of part 404 of this chapter). For purposes of entitlement to benefits as a surviving child (see § 410.212), such disability must have begun:

(i) Before the child attained age 22; however, no entitlement to child's benefits may be established for any month before January 1973, based on a disability which began after attainment of age 18; or

(ii) In the case of a student, before he ceased to be a student (see paragraph (c) of this section); or

(3) Is 18 years of age or older and is a student.

(c)(1) The term *student* means a *full-time student* as defined in section 202(d)(7) of the Social Security Act, 42 U.S.C. 402(d)(7) (see § 404.320(c) of this chapter), or an individual under 23 years of age who has not completed 4 years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an institution which is:

(i) A school, college, or university operated or directly supported by the United States, or by a State or local government or political subdivision thereof; or

(ii) A school, college, or university which has been accredited by a State or by a State-recognized or nationally recognized accrediting agency or body; or

(iii) A school, college, or university not so accredited but whose credits are accepted, on transfer, by at least three institutions which are so accredited, for credit on the same basis as if transferred from an institution so accredited; or

(iv) A technical, trade, vocational, business, or professional school accredited or licensed by the Federal, or a State government or any political subdivision thereof, providing courses of not less than 3 months' duration that prepare the student for a livelihood in a trade, industry, vocation, or profession.

(2) A student will be considered to be ''pursuing a full-time course of study or training at an institution'' if he is enrolled in a noncorrespondence course and is carrying a subject load which is considered full time for day students under the institution's standards and practices. However, a student will not be considered to be ''pursuing a full-time course of study or training'' if he is enrolled in a course of study or training of less than 13 school weeks' duration. A student beginning or ending a full-time course of study or training in part of any month will be considered to be pursuing such course for the entire month.

(3) A child is deemed not to have ceased to be a student:

(i) During any interim between school years, if the interim does not exceed 4 months and he shows to the satisfaction of the Administration that he has a bona fide intention of continuing to pursue a full-time course of study or training during the semester or other enrollment period immediately after the interim; or

(ii) During periods of reasonable duration during which, in the judgment of the Administration, he is prevented by factors beyond his control from pursuing his education.

(4) A student who completes 4 years of education beyond the high school level, or whose 23rd birthday occurs during a semester or other enrollment period in which he is pursuing a full-time course of study or training shall continue to be considered a student for as long as he otherwise qualifies under this section until the end of such period.

[37 FR 20639, Sept. 30, 1972, as amended at 41 FR 7091, Feb. 17, 1976]

§ 410.380 Determination of dependency; parent, brother, or sister.

An individual who is the miner's parent, brother, or sister (see § 410.340) will be determined to have been dependent on the miner if, during the 1-year period immediately prior to such miner's death:

(a) Such individual and the miner were living in the same household (see § 410.393); and

(b) Such individual was totally dependent on the miner for support (see § 410.395(h)).

[37 FR 20640, Sept. 30, 1972]

§ 410.390 Time of determinations.

(a) *Relationship and dependency of wife or child.* With respect to the wife or child of a miner entitled to benefits, and with respect to the child of a widow entitled to benefits, the determination as to whether an individual

purporting to be a wife or child is related to or dependent upon such miner or widow shall be based on the facts and circumstances with respect to the period of time as to which such issue of relationship or dependency is material. (See, for example, § 410.510(c).)

(b) *Relationship and dependency of widow.* The determination as to whether an individual purporting to be the widow of a miner was related to or dependent upon such miner is made after such individual effectively files a claim for benefits (see § 410.227) as a widow. Such determination is based on the facts and circumstances with respect to the time of the miner's death (except as provided in § 410.320(d)). A prior determination that such individual was determined to be, or not to be, the wife of such miner, pursuant to §§ 410.310 and 410.350, for purposes of augmenting the miner's benefits for a certain period (see § 410.510(c)), is not determinative of the issue of whether the individual is the widow of such miner or of whether she was dependent on such miner.

(c) *Relationship and dependency of surviving divorced wife.* The determination as to whether an individual purporting to be a surviving divorced wife of a miner was related to or dependent upon such miner is made when such individual effectively files a claim for benefits (see § 410.227) as a surviving divorced wife. Such determination is made with respect to the time of the miner's death. A prior determination that such individual was, or was not, the divorced wife of such miner, pursuant to §§ 410.311 and 410.351, for purposes of augmenting the miner's benefits for a certain period (see § 410.510(c)), is not determinative of the issue of whether the individual is the surviving divorced wife of such miner or of whether she was dependent on such miner.

[37 FR 20640, Sept. 30, 1972]

§ 410.391 Legal impediment.

For purposes of this subpart C, *legal impediment* means an impediment resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution, or resulting from a defect in the procedure followed in connection with the purported marriage ceremony—for example, the solemnization of a marriage only through a religious ceremony in a country which requires a civil ceremony for a valid marriage.

[36 FR 23756, Dec. 14, 1971]

§ 410.392 Domicile.

(a) For purposes of this subpart C, the term *domicile* means the place of an individual's true, fixed, and permanent home to which, whenever he is absent, he has the intention of returning.

(b) The domicile of a deceased miner or widow is determined as of the time of his or her death.

(c) The domicile or a change in domicile of a beneficiary or other individual is determined with respect to the period or periods of time as to which the issue of domicile is material.

(d) If an individual was not domiciled in any State at the pertinent time, the law of the District of Columbia is applied as if such individual were then domiciled there.

[36 FR 23756, Dec. 14, 1971, as amended at 37 FR 20640, Sept. 30, 1972]

§ 410.393 "Member of the same household"; "living with"; "living in the same household"; and "living in the miner's household".

(a) *Defined.* (1) The term *member of the same household* as used in section 402(a)(2) of the Act (with respect to a wife); the term *living with* as used in section 402(e) of the Act (with respect to a widow); and the term *living in the same household* as used in §§ 410.310(d) and 410.320(d) (with respect to certain wives and widows, respectively), mean that a husband and wife were customarily living together as husband and wife in the same place of abode.

(2) The term *living in the miner's household* as used in section 412(a)(5) of the Act (with respect to a parent, brother, or sister (see § 410.380)), means that the miner and such parent, brother, or sister, were sharing the same residence.

(b) *Temporary absence.* The temporary absence from the same residence of either the miner, or his wife, parent, brother, or sister (as the case may be), does not preclude a finding that one was *living with* the other, or that they were *members of the same household,* etc. The absence of one such individual from the residence in which both had

customarily lived shall, in the absence of evidence to the contrary, be considered temporary;

(1) If such absence was due to service in the Armed Forces of the United States; or

(2) If the period of absence from his or her residence did not exceed 6 months, and neither individual was outside the United States, and the absence was due to business or employment reasons, or because of confinement in a penal institution or in a hospital, nursing home, or other curative institution; or

(3) In any other case, if the evidence establishes that despite such absence they nevertheless reasonably expected to resume physically living together at some time in the reasonably near future.

(c) *Death during absence.* Where the death of one of the parties occurred while away from the residence for treatment or care of an illness or an injury (e.g., in a hospital), the fact that the death was foreseen as possible or probable does not in and of itself preclude a finding that the parties were ''living with'' one another or were ''member[s] of the same household'' etc. at the time of death.

(d) *Absences other than temporary.* In situations other than those described in paragraphs (b) and (c) of this section, the absence shall not be considered temporary, and the parties may not be found to be ''living with'' one another or to be ''member[s] of the same household'' etc. A finding of temporary absence would not be justified where one of the parties was committed to a penal institution for life or for a period exceeding the reasonable life expectancy of either, or was under a sentence of death; or where the parties had ceased to live in the same place of abode because of marital or family difficulties and had not resumed living together before death.

(e) *Relevant period of time.* (1) The determination as to whether a widow had been ''living with'' her husband shall be based upon the facts and circumstances as of the time of death of the miner.

(2) The determination as to whether a wife is a ''member of the same household'' as her husband shall be based upon the facts and circumstances with respect to the period or periods of time as to which the issue of membership in the same household is material. (See §410.510(c).)

(3) The determination as to whether a parent, brother, or sister was ''living in the miner's household'' shall take account only of the 1-year period immediately prior to the miner's death. (See §410.380.)

[37 FR 20640, Sept. 30, 1972]

§410.394 [Reserved]

§410.395 Contributions and support.

(a) *Support* defined. The term *support* includes food, shelter, clothing, ordinary medical expenses, and other ordinary and customary items for the maintenance of the person supported.

(b) *Contributions* defined. The term *contributions* refers to contributions actually provided by the contributor from his own property, or the use thereof, or by the use of his own credit.

(c) *Regular contributions* and *substantial contributions* defined. The terms *regular contributions* and *substantial contributions* mean contributions that are customary and sufficient to constitute a material factor in the cost of the individual's support.

(d) *Contributions and community property.* When a wife receives, and uses for her support, income from her services or property and such income, under applicable State law, is the community property of herself and the miner, no part of such income is a *contribution* by the miner to his wife's support regardless of any legal interest the miner may have therein. However, when a wife receives, and uses for her support, income from the services and the property of the miner and, under applicable State law, such income is community property, all of such income is considered to be a contribution by the miner to his wife's support.

(e) *Court order for support* defined. References to support orders in §§410.330 (f)(1), 410.350(c), and 410.360(b) mean any court order, judgment, or decree of a court of competent jurisdiction which requires regular contributions that are a material factor in the cost of the individual's support and which is in effect at the applicable

time. If such contributions are required by a court order, this condition is met whether or not the contributions were actually made.

(f) *Written agreement* defined. The term *written agreement* in the phrase *substantial contributions * * * pursuant to a written agreement* (see §§ 410.351 (b) and 410.361(b)) means an agreement signed by the miner providing for substantial contributions by him for the individual's support. It must be in effect at the applicable time but it need not be legally enforceable.

(g) *One-half support* defined. The term *one-half support* means that the miner made regular contributions, in cash or in kind, to the support of a divorced wife (see § 410.351(a)), or of a surviving divorced wife (see § 410.361 (a)), at the specified time or for the specified period, and that the amount of such contributions equaled or exceeded one-half the total cost of such individual's support at such time or during such period.

(h) *Totally dependent for support* defined. The term *totally dependent on the miner for support* as used in § 410.380(b), means that such miner made regular contributions to the support of his parent, brother, or sister, as the case may be, and that the amount of such contributions at least equaled the total cost of such individual's support.

[37 FR 20641, Sept. 30, 1972]

Subpart D—Total Disability or Death Due to Pneumoconiosis

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), secs. 401-426, 83 Stat. 792, as amended, 86 Stat. 150; 30 U.S.C. 901 *et. seq.*

SOURCE: 37 FR 20641, Sept. 30, 1972, unless otherwise noted.

§ 410.401 Scope of subpart D.

(a) *General.* This subpart establishes the standards for determining whether a coal miner is totally disabled due to pneumoconiosis, whether he was totally disabled due to pneumoconiosis at the time of his death, or whether his death was due to pneumoconiosis.

(b) *Pneumoconiosis* defined. *Pneumoconiosis* means:

(1) A chronic dust disease of the lung arising out of employment in the Nation's coal mines, and includes coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis, arising out of such employment. For purposes of this subpart, the term also includes the following conditions that may be the basis for application of the statutory presumption of disability or death due to pneumoconiosis under the circumstances prescribed in section 411 (c) of the Act;

(2) Any other chronic respiratory or pulmonary impairment when the conditions are met for the application of the presumption described in § 410.414(b) or § 410.454(b), and

(3) Any respirable disease when the conditions are met for the application of the presumption described in § 410.462. The provisions for determining that a miner is or was totally disabled due to pneumoconiosis or its sequelae are included in §§ 410.410 through 410.430 and in the appendix following this subpart D. The provisions for determining that a miner's death was due to pneumoconiosis are included in §§ 410.450 through 410.462. Certain related provisions of general application are included in §§ 410.470 through 410.476.

(c) *Relation to the Social Security Act.* Section 402(f) of the Act, as amended, 30 U.S.C. 902(f), provides that regulations defining total disability ''shall not provide more restrictive criteria than those applicable under section 223(d) of the Social Security Act.'' Section 413(b) of the Act, 30 U.S.C. 923(b), also provides, in pertinent part, that in ''carrying out the provisions of this part [that is, part B of title IV of the Act], the Commissioner shall to the maximum extent feasible (and consistent with the provisions of this part) utilize the * * * procedures he uses in determining entitlement to disability insurance benefits under section 223 of the Social Security Act * * *.''

[37 FR 20641, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§410.410 Total disability due to pneumoconiosis, including statutory presumption.

(a) Benefits are provided under the Act to coal miners ''who are totally disabled due to pneumoconiosis arising out of employment in one or more of the Nation's coal mines,'' and to the eligible survivors of miners who are determined to have been totally disabled due to pneumoconiosis at the time of their death. (For benefits to the eligible survivors of miners whose deaths are determined to have been due to pneumoconiosis, see §410.450.)

(b) To establish entitlement to benefits on the basis of a coal miner's total disability due to pneumoconiosis, a claimant must submit the evidence necessary to establish: (1) That he is a coal miner, that he is totally disabled due to pneumoconiosis, and that his pneumoconiosis arose out of employment in the Nation's coal mines; or (2) that the deceased individual was a miner, that he was totally disabled due to pneumoconiosis at the time of his death, and that his pneumoconiosis arose out of employment in the Nation's coal mines.

(c) Total disability is defined in §410.412; the basic provision on determining the existence of pneumoconiosis is in §410.414; and the requirement that the pneumoconiosis must have arisen out of coal mine employment is in §410.416. The statutory presumptions with respect to the burden of proving the foregoing are in §§410.414(b), 410.416(a), and 410.418, and the provision for determining the existence of total disability when the presumption in §410.418 does not apply is included in §410.422.

§410.412 "Total disability" defined.

(a) A miner shall be considered totally disabled due to pneumoconiosis if:

(1) His pneumoconiosis prevents him from engaging in gainful work in the immediate area of his residence requiring the skills and abilities comparable to those of any work in a mine or mines in which he previously engaged with some regularity and over a substantial period of time (that is, ''comparable and gainful work''; see §§410.424 through 410.426); and

(2) His impairment can be expected to result in death, or has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) A miner shall be considered to have been totally disabled due to pneumoconiosis at the time of his death, if at the time of his death:

(1) His pneumoconiosis prevented him from engaging in gainful work in the immediate area of his residence requiring the skills and abilities comparable to those of any work in a mine or mines in which he previously engaged with some regularity and over a substantial period of time (that is, ''comparable and gainful work''; see §§410.424 through 410.426); and

(2) His impairment was expected to result in death, or it lasted or was expected to last for a continuous period of not less than 12 months.

§410.414 Determining the existence of pneumoconiosis, including statutory presumption.

(a) *General.* A finding of the existence of pneumoconiosis as defined in §410.110(o)(1) may be made under the provisions of §410.428 by:

(1) Chest roentgenogram (X-ray); or

(2) Biopsy; or

(3) Autopsy.

(b) *Presumption relating to respiratory or pulmonary impairment.* (1) Even though the existence of pneumoconiosis is not established as provided in paragraph (a) of this section, if other evidence demonstrates the existence of a totally disabling chronic respiratory or pulmonary impairment (see §§410.412, 410.422, and 410.426), it may be presumed, in the absence of evidence to the contrary (see paragraph (b)(2) of this section), that a miner is totally disabled due to pneumoconiosis, or that a miner was totally disabled due to pneumoconiosis at the time of his death.

(2) This presumption may be rebutted only if it is established that the miner does not, or did not, have pneumoconiosis, or that his respiratory or pulmonary impairment did not arise out of, or in connection with, employment in a coal mine.

(3) The provisions of this paragraph shall apply where a miner was employed for 15 or more years in one or

more of the Nation's underground coal mines; in one or more of the Nation's other coal mines where the environmental conditions were substantially similar to those in an underground coal mine; or in any combination of both.

(4) However, where the evidence shows a work history reflecting many years of such coal mine employment (although less than 15), as well as a severe lung impairment, such evidence may be considered, in the exercise of sound judgment, to establish entitlement in such case, provided that a mere showing of a respiratory or pulmonary impairment shall not be sufficient to establish such entitlement.

(c) *Other relevant evidence.* Even though the existence of pneumoconiosis is not established as provided in paragraph (a) or (b) of this section, a finding of total disability due to pneumoconiosis may be made if other relevant evidence establishes the existence of a totally disabling chronic respiratory or pulmonary impairment, and that such impairment arose out of employment in a coal mine. As used in this paragraph, the term *other relevant evidence* includes medical tests such as blood gas studies, electrocardiogram, pulmonary function studies, or physical performance tests, and any medical history, evidence submitted by the miner's physician, his spouse's affidavits, and in the case of a deceased miner, other appropriate affidavits of persons with knowledge of the individual's physical condition, and other supportive materials. In any event, no claim for benefits under part B of title IV of the Act shall be denied solely on the basis of a negative chest roentgenogram (X-ray).

§ 410.416 Determining origin of pneumoconiosis, including statutory presumption.

(a) If a miner was employed for 10 or more years in the Nation's coal mines, and is suffering or suffered from pneumoconiosis, it will be presumed, in the absence of persuasive evidence to the contrary, that the pneumoconiosis arose out of such employment.

(b) In any other case, a miner who is suffering or suffered from pneumoconiosis, must submit the evidence necessary to establish that the pneumoconiosis arose out of employment in the Nation's coal mines. (See § 410.110 (h), (i), (j), (k), (l), and (m).)

§ 410.418 Irrebuttable presumption of total disability due to pneumoconiosis.

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, or that a miner was totally disabled due to pneumoconiosis at the time of his death, if he is suffering or suffered from a chronic dust disease of the lung which:

(a) When diagnosed by chest roentgenogram (X-ray), yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C (that is, as *complicated pneumoconiosis*), in:

(1) The ILO–U/C International Classification of Radiographs of Pneumoconioses, 1971, or

(2) The International Classification of the Radiographs of the Pneumoconioses of the International Labour Office, Extended Classification (1968) (which may be referred to as the ''ILO Classification (1968)''), or

(3) The Classification of the Pneumoconiosis of the Union Internationale Contra Cancer/Cincinnati (1968) (which may be referred to as the ''UICC/Cincinnati (1968) Classification''); or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung. The report of biopsy or autopsy will be accepted as evidence of complicated pneumoconiosis if the histological findings show simple pneumoconiosis and progressive massive fibrosis; or

(c) When established by diagnoses by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnoses been made as therein prescribed; *Provided, however,* That any diagnoses made under this paragraph shall accord with generally accepted medical procedures for diagnosing pneumoconiosis.

§ 410.422 Determining total disability: General criteria.

(a) A determination of total disability due to pneumoconiosis is made

in accordance with this section when a miner cannot be presumed to be totally disabled due to pneumoconiosis (or to have been totally disabled due to pneumoconiosis at the time of his death), under the provisions of § 410.418. In addition, when a miner has (or had) a chronic respiratory or pulmonary impairment, a determination of whether or not such impairment is (or was) totally disabling is also made in accordance with this section for purposes of § 410.414(b).

(b) A determination of total disability may not be made for purposes of this part unless pneumoconiosis is (or is presumed to be) the impairment involved.

(c) Whether or not the pneumoconiosis in a particular case renders (or rendered) a miner totally disabled, as defined in § 410.412, is determined from all the facts of that case. Primary consideration is given to the medical severity of the individual's pneumoconiosis (see § 410.424). Consideration is also given to such other factors as the individual's age, education, and work experience (see § 410.426).

§ 410.424 Determining total disability: Medical criteria only.

(a) Medical considerations alone shall justify a finding that a miner is (or was) totally disabled where his impairment is one that meets (or met) the duration requirement in § 410.412(a)(2) or § 410.412(b)(2), and is listed in the appendix to this subpart, or if his impairment is medically the equivalent of a listed impairment. However, medical considerations alone shall not justify a finding that an individual is (or was) totally disabled if other evidence rebuts such a finding, e.g., the individual is (or was) engaged in comparable and gainful work (see § 410.412).

(b) An individual's impairment shall be determined to be medically the equivalent of an impairment listed in the appendix to this subpart only if the medical findings with respect thereto are at least equivalent in severity and duration to the listed findings of the listed impairment. Any decision as to whether an individual's impairment is medically the equivalent of an impairment listed in the appendix to this subpart, shall be based on medically accepted clinical and laboratory diagnostic techniques, including a medical judgment furnished by one or more physicians designated by the Administration, relative to the question of medical equivalence.

§ 410.426 Determining total disability: Age, education, and work experience criteria.

(a) Pneumoconiosis which constitutes neither an impairment listed in the appendix to this subpart (see § 410.424), nor the medical equivalent thereof, shall nevertheless be found totally disabling if because of the severity of such impairment, the miner is (or was) not only unable to do his previous coal mine work, but also cannot (or could not), considering his age, his education, and work experience, engage in any other kind of comparable and gainful work (see § 410.412(a)(1)) available to him in the immediate area of his residence. A miner shall be determined to be under a disability only if his pneumoconiosis is (or was) the primary reason for his inability to engage in such comparable and gainful work. Medical impairments other than pneumoconiosis may not be considered.

The following criteria recognize that an impairment in the transfer of oxygen from the lung alveoli to cellular level can exist in an individual even though his chest roentgenogram (X-ray) or ventilatory function tests are normal.

(b) Subject to the limitations in paragraph (a) of this section, pneumoconiosis shall be found disabling if it is established that the miner has (or had) a respiratory impairment because of pneumoconiosis demonstrated on the basis of a ventilatory study in which the maximum voluntary ventilation (MVV) or maximum breathing capacity (MBC), and 1-second forced expiratory volume (FEV_1), are equal to or less than the values specified in the following table or by a medically equivalent test:

Height (inches)	MVV (MBC) equal to or less than L./Min.	FEV_1 equal to or less than l.
57 or less	52	1.4
58	53	1.4

Height (inches)	MVV (MBC) equal to or less than L./Min.	FEV_1 equal to or less than l.
59	54	1.4
60	55	1.5
61	56	1.5
62	57	1.5
63	58	1.5
64	59	1.6
65	60	1.6
66	61	1.6
67	62	1.7
68	63	1.7
69	64	1.8
70	65	1.8
71	66	1.8
72	67	1.9
73 or more	68	1.9

(c) Where the values specified in paragraph (b) of this section are not met, pneumoconiosis may nevertheless be found disabling if a physical performance test establishes a chronic respiratory or pulmonary impairment which is medically the equivalent of the values specified in the table in paragraph (b) of this section. Any decision with respect to such medical equivalence shall be based on medically accepted clinical and laboratory diagnostic techniques including a medical judgment furnished by one or more physicians designated by the Administration.

(d) Where a ventilatory study and/or a physical performance test is medically contraindicated, or cannot be obtained, or where evidence obtained as a result of such tests does not establish that the miner is totally disabled, pneumoconiosis may nevertheless be found totally disabling if other relevant evidence (see § 410.414(c)) establishes that the miner has (or had) a chronic respiratory or pulmonary impairment, the severity of which prevents (or prevented) him not only from doing his previous coal mine work, but also, considering his age, his education, and work experience, prevents (or prevented) him from engaging in comparable and gainful work.

(e) When used in this section, the term *age* refers to chronological age and the extent to which it affects the miner's capacity to engage in comparable and gainful work.

(f) When used in this section, the term *education* is used in the following sense: Education and training are factors in determining the employment capacity of a miner. Lack of formal schooling, however, is not necessarily proof that a miner is an uneducated person. The kinds of responsibilities with which he was charged when working may indicate ability to do more than unskilled work even though his formal education has been limited.

§ 410.428 X-ray, biopsy, and autopsy evidence of pneumoconiosis.

(a) A finding of the existence of pneumoconiosis as defined in § 410.110(o)(1) may be made under the provisions of § 410.414(a) if:

(1) A chest roentgenogram (X-ray) establishes the existence of pneumoconiosis classified as Category 1, 2, 3, A, B, or C according to:

(i) The ILO–U/C International Classification of Radiographs of Pneumoconioses, 1971; or

(ii) The International Classification of Radiographs of the Pneumoconioses of the International Labour Office, Extended Classification (1968); or

(iii) The Classification of the Pneumoconioses of the Union Internationale Contra Cancer/Cincinnati (1968).

A chest roentgenogram (X-ray) classified as Category Z under the ILO Classification (1958) or Short Form (1968) will be reclassified as Category 0 or Category 1 and only the latter accepted as evidence of pneumoconiosis. A chest roentgenogram (X-ray) classified under any of the foregoing classifications as Category 0, including subcategories o/–, o/o, or o/1 under the UICC/Cincinnati (1968) Classification, is not accepted as evidence of pneumoconiosis; or

(2) An autopsy shows the existence of pneumoconiosis, or

(3) A biopsy (other than a needle biopsy) shows the existence of pneumoconiosis. Such biopsy would not be expected to be performed for the sole purpose of diagnosing pneumoconiosis. Where a biopsy is performed for other purposes, however (e.g., in connection with a lung resection), the report thereof will be considered in determining the existence of pneumoconiosis.

(b) The roentgenogram shall be of suitable quality for proper classification of the pneumoconioses and conform to accepted medical standards. It should represent a posterior-anterior view of the chest, and such other views as the Administration may require, taken at a preferred distance of 6 feet (a minimum of 5 feet is required) between the focal point and the film on a 14 × 17 inch or 14 × 14 inch X-ray film. Additional films or views should be obtained, if necessary, to provide a suitable roentgenogram (X-ray) for proper classification purposes.

(c) A report of autopsy or biopsy shall include a detailed gross (macroscopic) and microscopic description of the lungs or visualized portion of a lung. If an operative procedure has been performed to obtain a portion of a lung, the evidence should include a copy of the operative note and the pathology report of the gross and microscopic examination of the surgical specimen. If any autopsy has been performed, the evidence should include a complete copy of the autopsy report.

§410.430 Ventilatory studies.

Spirometric tests to measure ventilatory function must be expressed in liters or liters per minute. The reported maximum voluntary ventilation (MVV) or maximum breathing capacity (MBC) and 1-second forced expiratory volume (FEV_1) should represent the largest of at least three attempts. The MVV or the MBC reported should represent the observed value and should not be calculated from FEV_1. The three appropriately labeled spirometric tracings, showing distance per second on the abscissa and the distance per liter on the ordinate, must be incorporated in the file. The paper speed to record the FEV_1 should be at least 20 millimeters (mm.) per second. The height of the individual must be recorded. Studies should not be performed during or soon after an acute respiratory illness. If wheezing is present on auscultation of the chest, studies must be performed following administration of nebulized broncho-dilator unless use of the later is contraindicated. A statement shall be made as to the individual's ability to understand the directions, and cooperate in performing the tests. If the tests cannot be completed the reason for such failure should be explained.

§410.432 Cessation of disability.

(a) Where it has been determined that a miner is totally disabled under §410.412, such disability shall be found to have ceased in the month in which his impairment, as established by medical or other relevant evidence, is no longer of such severity as to prevent him from engaging in comparable and gainful work.

(b) Except where a finding is made as specified in paragraph (a) of this section which results in an earlier month of cessation, if a miner is requested to furnish necessary medical or other evidence or to present himself for a necessary medical examination by a date specified in the request or a date extended at the miner's request for good cause, and the miner fails to comply with such request, the disability may be found to have ceased in the month within which the date for compliance falls, unless the Administration determines that there is a good cause for such failure.

(c) Before a determination is made that a miner's disability has ceased, such miner shall be given notice and an opportunity to present evidence including that from medical sources of his own choosing and arguments and contention that his disability has not ceased.

§410.450 Death due to pneumoconiosis, including statutory presumption.

Benefits are provided under the Act to the eligible survivor of a coal miner who was entitled to benefits at the time of his death, or whose death is determined to have been due to pneumoconiosis. (For benefits to the eligible survivors of a miner who is determined to have been totally disabled due to pneumoconiosis at the time of his death, regardless of the cause of death, see §§410.410 through 410.430.) Except as otherwise provided in §§410.454 through 410.462, the claimant must submit the evidence necessary to establish that the miner's death was due to pneumoconiosis and that the pneumoconiosis arose out of employment in the Nation's coal mines.

§ 410.454 Determining the existence of pneumoconiosis, including statutory presumption—survivor's claim.

(a) *Medical findings.* A finding of the existence of pneumoconiosis as defined in § 410.110(o)(1) may be made under the provisions of § 410.428 by:

(1) Chest roentgenogram; or

(2) Biopsy; or

(3) Autopsy.

(b) *Presumption relating to respiratory or pulmonary impairment—survivor's claim.* (1) Even though the existence of pneumoconiosis is not established as provided in paragraph (a) of this section, if other evidence demonstrates the existence of a chronic respiratory or pulmonary impairment from which the miner was totally disabled (see § 410.412) prior to his death, it will be presumed in the absence of evidence to the contrary (see paragraph (b)(2) of this section) that the death of the miner was due to pneumoconiosis.

(2) This presumption may be rebutted only if it is established that the miner did not have pneumoconiosis, or that his respiratory or pulmonary impairment did not arise out of, or in connection with, employment in a coal mine.

(3) The provisions of this paragraph shall apply where a miner was employed for 15 or more years in one or more of the Nation's underground coal mines; in one or more of the Nation's other coal mines where the environmental conditions were substantially similar to those in an underground coal mine; or in any combination of both.

(4) However, where the evidence shows a work history reflecting many years of such coal mine employment (although less than 15) as well as a severe lung impairment, such evidence may be considered, in the exercise of sound judgment, to establish entitlement in such case: *Provided,* That a mere showing of a respiratory or pulmonary impairment shall not be sufficient to establish such entitlement.

(c) *Other relevant evidence.* Even though the existence of pneumoconiosis is not established as provided in paragraph (a) or (b) of this section, a finding of death due to pneumoconiosis may be made if other relevant evidence establishes the existence of a totally disabling chronic respiratory or pulmonary impairment, and that such impairment arose out of employment in a coal mine. As used in this paragraph, the term *other relevant evidence* includes medical tests such as blood gas studies, electrocardiogram, pulmonary function studies, or physical performance tests, and any medical history, evidence submitted by the miner's physician, his spouse's affidavits, and in the case of a deceased miner, other appropriate affidavits of persons with knowledge of the individual's physical condition, and other supportive materials. In any event, no claim for benefits under part B of title IV of the Act shall be denied solely on the basis of a negative chest roentgenogram (X-ray).

§ 410.456 Determining origin of pneumoconiosis, including statutory presumption—survivor's claim.

(a) If a miner was employed for 10 years or more in the Nation's coal mines, and suffered from pneumoconiosis, it will be presumed, in the absence of persuasive evidence to the contrary, that the pneumoconiosis arose out of such employment.

(b) In any other case, the claimant must submit the evidence necessary to establish that the pneumoconiosis from which the deceased miner suffered, arose out of employment in the Nation's coal mines. (See § 410.110 (h), (i), (j), (k), (l), and (m).)

§ 410.458 Irrebuttable presumption of death due to pneumoconiosis—survivor's claim.

There is an irrebuttable presumption that the death of a miner was due to pneumoconiosis if he suffered from a chronic dust disease of the lung which meets the requirements of § 410.418.

§ 410.462 Presumption relating to respirable disease.

(a) Even though the existence of pneumoconiosis as defined in § 410.110 (o)(1) is not established as provided in § 410.454(a), if a deceased miner was employed for 10 years or more in the Nation's coal mines and died from a respirable disease, it will be presumed, in the absence of evidence to the contrary, that his death was due to pneumoconiosis arising out of employment in a coal mine.

(b) Death will be found due to a respirable disease when death is medically ascribed to a chronic dust disease, or to another chronic disease of the lung. Death will not be found due to a respirable disease where the disease reported does not suggest a reasonable possibility that death was due to pneumoconiosis. Where the evidence establishes that a deceased miner suffered from pneumoconiosis or a respirable disease and death may have been due to multiple causes, death will be found due to pneumoconiosis if it is not medically feasible to distinguish which disease caused death or specifically how much each disease contributed to causing death.

§410.470 Determination by nongovernmental organization or other governmental agency.

The decision of any nongovernmental organization or any other governmental agency that an individual is, or is not, disabled for purposes of any contract, schedule, regulation, or law, or that his death was or was not due to a particular cause, shall not be determinative of the question of whether or not an individual is totally disabled due to pneumoconiosis, or was totally disabled due to pneumoconiosis. As used in this section, the term *other governmental agency* includes the Administration with respect to a determination or decision relating to entitlement to disability insurance benefits under section 223 of the Social Security Act, since the requirements for entitlement under the latter Act differ from those relating to benefits under this part. However, a final determination or decision that an individual is disabled for purposes of section 223 of the Social Security Act where the cause of such disability is pneumoconiosis, shall be binding on the Administration on the issue of disability with respect to claims under this part.

§410.471 Conclusion by physician regarding miner's disability or death.

The function of deciding whether or not an individual is totally disabled due to pneumoconiosis, or was totally disabled due to pneumoconiosis at the time of his death, or that his death was due to pneumoconiosis, is the responsibility of the Administration. A statement by a physician that an individual is, or is not, *disabled, permanently disabled, totally disabled, totally and permanently disabled, unable to work,* or a statement of similar import, being a conclusion upon the ultimate issue to be decided by the Administration, shall not be determinative of the question of whether or not an individual is under a disability. However, all statements and other evidence (including statements of the miner's physician) shall be considered in adjudicating a claim. In considering statements of the miner's physician, appropriate account shall be taken of the length of time he treated the miner.

§410.472 Consultative examinations.

Upon reasonable notice of the time and place thereof, any individual filing a claim alleging to be totally disabled due to pneumoconiosis shall present himself for and submit to reasonable physical examinations or tests, at the expense of the Administration, by a physician or other professional or technical source designated by the Administration or the State agency authorized to make determinations as to disability. If any such individual fails or refuses to present himself for any examination or test, such failure or refusal, unless the Administration determines that there is good cause therefor, may be a basis for determining that such individual is not totally disabled. Religious or personal scruples against medical examination or test shall not excuse an individual from presenting himself for a medical examination or test. Any claimant may request that such test be performed by a physician or other professional or technical source of his choice, the reasonable expense of which shall be borne by the Administration (see §410.240(h)). However, granting such request does not preclude the Administration from requiring that additional or supplemental tests be conducted by a physician or other professional or technical source designated by the Administration.

§ 410.473 Evidence of continuation of disability.

An individual who has been determined to be totally disabled due to pneumoconiosis, upon reasonable notice, shall, if requested to do so (e.g., where there is an issue about the validity of the original adjudication of disability) present himself for and submit to examinations or tests as provided in § 410.472, and shall submit medical reports and other evidence necessary for the purposes of determining whether such individual continues to be under a disability.

§ 410.474 Place and manner of submitting evidence.

Evidence in support of a claim for benefits based on disability shall be filed in the manner and at the place or places prescribed in subpart B of this part, or where appropriate, at the office of a State agency authorized under agreement with the Commissioner to make determinations as to disability under title II of the Social Security Act, or with an employee of such State agency authorized to accept such evidence at a place other than such office.

[37 FR 20641, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§ 410.475 Failure to submit evidence.

An individual shall not be determined to be totally disabled unless he furnishes such medical and other evidence thereof as is reasonably required to establish his claim. Religious or personal scruples against medical examinations, tests, or treatment shall not excuse an individual from submitting evidence of disability.

§ 410.476 Responsibility to give notice of event which may affect a change in disability status.

An individual who is determined to be totally disabled due to pneumoconiosis shall notify the Administration promptly if:

(a) His respiratory or pulmonary condition improves; or

(b) He engages in any gainful work or there is an increase in the amount of such work or his earnings therefrom.

§ 410.490 Interim adjudicatory rules for certain part B claims filed by a miner before July 1, 1973, or by a survivor where the miner died before January 1, 1974.

(a) *Basis for rules.* In enacting the Black Lung Act of 1972, the Congress noted that adjudication of the large backlog of claims generated by the earlier law could not await the establishment of facilities and development of medical tests not presently available to evaluate disability due to pneumoconiosis, and that such claims must be handled under present circumstances in the light of limited medical resources and techniques. Accordingly, the Congress stated its expectancy that the Commissioner would adopt such interim evidentiary rules and disability evaluation criteria as would permit prompt and vigorous processing of the large backlog of claims consistent with the language and intent of the 1972 amendments and that such rules and criteria would give full consideration to the combined employment handicap of disease and age and provide for the adjudication of claims on the basis of medical evidence other than physical performance tests when it is not feasible to provide such tests. The provisions of this section establish such interim evidentiary rules and criteria. They take full account of the congressional expectation that in many instances it is not feasible to require extensive pulmonary function testing to measure the total extent of an individual's breathing impairment, and that an impairment in the transfer of oxygen from the lung alveoli to cellular level can exist in an individual even though his chest roentgenogram (X-ray) or ventilatory function tests are normal.

(b) *Interim presumption.* With respect to a miner who files a claim for benefits before July 1, 1973, and with respect to a survivor of a miner who dies before January 1, 1974, when such survivor timely files a claim for benefits, such miner will be presumed to be totally disabled due to pneumoconiosis, or to have been totally disabled due to pneumoconiosis at the time of his death, or his death will be presumed to be due to pneumoconiosis, as the case may be, if:

(1) One of the following medical requirements is met:

(i) A chest roentgenogram (X-ray), biopsy, or autopsy establishes the existence of pneumoconiosis (see §410.428); or

(ii) In the case of a miner employed for at least 15 years in underground or comparable coal mine employment, ventilatory studies establish the presence of a chronic respiratory or pulmonary disease (which meets the requirements for duration in §410.412(a)(2)) as demonstrated by values which are equal to or less than the values specified in the following table:

	Equal to or less than—	
	FEV_1	MVV
67″ or less	2.3	92
68″	2.4	96
69″	2.4	96
70″	2.5	100
71″	2.6	104
72″	2.6	104
73″ or more	2.7	108

(2) The impairment established in accordance with paragraph (b)(1) of this section arose out of coal mine employment (see §§410.416 and 410.456).

(3) With respect to a miner who meets the medical requirements in paragraph (b)(1)(ii) of this section, he will be presumed to be totally disabled due to pneumoconiosis arising out of coal mine employment, or to have been totally disabled at the time of his death due to pneumoconiosis arising out of such employment, or his death will be presumed to be due to pneumoconiosis arising out of such employment, as the case may be, if he has at least 10 years of the requisite coal mine employment.

(c) *Rebuttal of presumption.* The presumption in paragraph (b) of this section may be rebutted if:

(1) There is evidence that the individual is, in fact, doing his usual coal mine work or comparable and gainful work (see §410.412(a)(1)), or

(2) Other evidence, including physical performance tests (where such tests are available and their administration is not contraindicated), establish that the individual is able to do his usual coal mine work or comparable and gainful work (see §410.412(a)(1)).

(d) *Application of presumption on readjudication.* Any claim initially adjudicated under the rules in this section will, if the claim is for any reason thereafter readjudicated, be readjudicated under the same rules.

(e) *Failure of miner to qualify under presumption in paragraph (b) of this section.* Where it is not established on the basis of the presumption in paragraph (b) of this section that a miner is (or was) totally disabled due to pneumoconiosis, or was totally disabled due to pneumoconiosis at the time of his death, or that his death was due to pneumoconiosis, the claimant may nevertheless establish the requisite disability or cause of death of the miner under the rules set out in §§410.412 to 410.462.

[37 FR 20641, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

APPENDIX TO SUBPART D OF PART 410

A miner with pneumoconiosis who meets or met one of the following sets of medical specifications, may be found to be totally disabled due to pneumoconiosis at the pertinent time, in the absence of evidence rebutting such finding:

(1) Arterial oxygen tension at rest (sitting or standing) or during exercise and simultaneously determined arterial PCO_2 equal to, or less than, the values specified in the following table:

Arterial PCO_2 (mm. Hg)	Arterial PO_2 equal to or less than (mm. Hg)
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

or

(2) Cor pulmonale with right-sided congestive failure as evidenced by peripheral edema and liver enlargement, with:

(A) Right ventricular enlargement or outflow tract prominence on X-ray or fluoroscopy; or

(B) ECG showing QRS duration less than 0.12 second and R of 5 mm. or more in V_1 and R/S of 1.0 or more in V_1 and transition zone (decreasing R/S) left of V_1;

or

(3) Congestive heart failure with signs of vascular congestion such as hepatomegaly or peripheral or pulmonary edema, with:

(A) Cardio-thoracic ratio of 55 percent or greater, or equivalent enlargement of the transverse diameter of the heart, as shown on teleroentgenogram (6-foot film); or

(B) Extension of the cardiac shadow (left ventricle) to the vertebral column on lateral chest roentgenogram and total of S in V_1 or V_2 and R in V_5 or V_6 of 35 mm. or more on ECG.

Subpart E—Payment of Benefits

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), secs. 411(a), 412 (a) and (b), 413(b), 426(a), and 508, 83 Stat. 793; 30 U.S.C. 921(a), 922 (a) and (b), 923(b), 936(a), and 957; sec. 410.565 also issued under sec. 3, 80 Stat. 309, 31 U.S.C. 952, unless otherwise noted.

SOURCE: 36 FR 23758, Dec. 14, 1971, unless otherwise noted.

§ 410.501 Payment periods.

Benefits are paid to beneficiaries during entitlement for payment periods consisting of full calendar months.

§ 410.505 Payees.

(a) *General.* Benefits may be paid as appropriate, to a beneficiary (see § 410.110(r)), to a qualified dependent (see § 410.511), or to a representative payee on behalf of a beneficiary or dependent (see § 410.581ff). Also where an amount is payable under part B of title IV of the Act for any month to two or more individuals who are members of the same family, the Social Security Administration may, in its discretion, certify to any two or more of such individuals joint payment of the total benefits payable to them for such month.

(b) *Joint payee dies before cashing check.* Where a check has been issued for joint payment to an individual and spouse residing in the same household and one of them dies before the check is cashed, the Social Security Administration may give the survivor permission to cash the check. The permission is carried out by stamping the face of the check. An official of the Social Security Administration or the Treasury Disbursing Office must sign and name the survivor as the payee of the check (see 31 CFR 360.8). Where the uncashed check is for benefits for a month after the month of death, authority to cash the check will not be given to the surviving payee unless the funds are needed to meet the ordinary and necessary living expenses of the surviving payee.

(c) *Adjustment or recovery of overpayment.* Where a check representing payment of benefits to an individual and spouse residing in the same household is negotiated by the surviving payee in accordance with the authorization in paragraph (b) of this section and where the amount of the check exceeds the amount to which the surviving payee is entitled, appropriate adjustment or recovery with respect to such excess amount shall be made in accordance with section 204(a) of the Act (see subpart F of part 404).

[43 FR 34780, Aug. 7, 1978]

§ 410.510 Computation of benefits.

(a) *Basic rate.* The benefit amount of each beneficiary entitled to a benefit for a month is determined, in the first instance, by computing the ''basic rate.'' The basic rate is equal to 50 percent of the minimum monthly payment to which a totally disabled Federal employee in Grade GS–2 would be entitled for such month under the Federal Employees' Compensation Act, chapter 81, title 5 U.S.C. That rate for a month is determined by:

(1) Ascertaining the lowest annual rate of pay (''step 1'') for Grade GS–2 of the General Schedule applicable to such month (see 5 U.S.C. 5332);

(2) Ascertaining the monthly rate thereof by dividing the amount determined in paragraph (a)(1) of this section by 12;

(3) Ascertaining the minimum monthly payment under the Federal Employees' Compensation Act by multiplying the amount determined in paragraph (a)(2) of this section by 0.75 (that is, by 75 percent) (see 5 U.S.C. 8112); and

(4) Ascertaining the basic rate under the Act by multiplying the amount determined in paragraph (a)(3) of this section by 0.50 (that is, by 50 percent).

(b) *Basic benefit.* When a miner or widow is entitled to benefits for a month for which he or she has no dependents who qualify under subpart C of this part, and when a surviving child

of a miner or widow, or a parent, brother, or sister of a miner, is entitled to benefits for a month for which he or she is the only beneficiary entitled to benefits, the amount of benefits to which such beneficiary is entitled is equal to the basic rate as computed in accordance with this section (raised, if not a multiple of 10 cents, to the next higher multiple of 10 cents (see paragraph (d) of this section)). This amount is referred to as the *basic benefit.*

(c) *Augmented benefit.* (1) When a miner or widow is entitled to benefits for a month for which he or she has one or more dependents who qualify under subpart C of this part, the amount of benefits to which such miner or widow is entitled is increased. This increase is referred to as an *augmentation.*

(2) Any request to the Administration that the benefits of a miner or widow be augmented in accordance with this paragraph shall be in writing on such form and in accordance with such instructions as are prescribed by the Administration. Such request shall be filed with the Administration in accordance with those provisions of subpart B of this part dealing with the filing of claims as if such request were a claim for benefits, and as if such dependent were the *beneficiary* referred to therein. (See § 410.220(f).) Ordinarily, such request is made as part of the claim of the miner or widow for benefits.

(3) The benefits of a miner or widow are augmented to take account of a particular dependent beginning with the first month in which such dependent satisfies the conditions set forth in subpart C of this part, and continues to be augmented through the month before the month in which such dependent ceases to satisfy the conditions set forth in subpart C of this part, except in the case of a child who qualifies as a dependent because he is a student (see § 410.370(c)). In the latter case such benefits continue to be augmented through the month before the first month during no part of which he qualifies as a student.

(4) The basic rate is augmented by 50 percent for one such dependent, 75 percent for two such dependents, and 100 percent for three or more such dependents (see paragraph (d) of this section).

(d) *Benefit rates for miners and widows.*

	Beginning October 1976	Beginning October 1975	October 1974 to September 1975	October 1973 to September 1974	October 1972 to September 1973	January 1972 to September 1972	1971	1969–70
(1) Miner or widow with no dependents	$205.40	$196.80	$187.40	$177.60	$169.80	$161.50	$153.10	$144.50
(2) Miner or widow with one dependent	308.10	295.20	281.10	266.40	254.70	242.20	229.60	216.70
(3) Miner or widow with two dependents	359.50	344.40	328.00	310.80	297.10	282.60	267.90	252.80
(4) Miner or widow with three or more dependents	410.80	393.50	374.80	355.20	339.50	322.90	306.10	288.90

(e) *Survivor benefit.* (1) As used in this section, *survivor* means a surviving child of a miner or widow, or, for months beginning May 1972, a surviving parent, brother, or sister of a miner, who establishes entitlement to benefits under the provisions of subpart B of this part.

(2) When one survivor is entitled to benefits for a month, his benefit is the amount specified in paragraph (d)(1) of this section; when two survivors are so entitled, the benefit of each is one-half the amount specified in paragraph (d)(2) of this section; when three survivors are so entitled, the benefit of each is one-third the amount specified in paragraph (d)(3) of this section; when four survivors are so entitled, the benefit of each is one-quarter of the amount specified in paragraph (d)(4) of this section; and when more than four survivors are so entitled, the benefit of each is determined by dividing the amount specified in paragraph (d)(4) of this section by the number of such survivors.

(f) *Computation and rounding.* (1) Any computation prescribed by this section is made to the third decimal place.

(2) Monthly benefits are payable in multiples of 10 cents. Therefore, a monthly payment of amounts derived under paragraph (c)(4) or (e)(2) of this

section which is not a multiple of 10 cents is increased to the next higher multiple of 10 cents.

(3) Since a fraction of a cent is not a multiple of 10 cents, such an amount which contains a fraction in the third decimal place is raised to the next higher multiple of 10 cents.

(g) *Eligibility based on the coal mine employment of more than one miner.* Where an individual, for any month, is entitled (and/or qualifies as a dependent for purposes of augmentation of benefits) based on the disability or death due to pneumoconiosis arising out of the coal mine employment of more than one miner, the benefit payable to or on behalf of such individual shall be at a rate equal to the highest rate of benefits for which entitlement is established by reason of eligibility as a beneficiary, or by reason of his or her qualification as a dependent for augmentation of benefit purposes.

[37 FR 20646, Sept. 30, 1972, as amended at 39 FR 12098, Apr. 3, 1974; 39 FR 41977, Dec. 4, 1974; 40 FR 56887, Dec. 5, 1975; 41 FR 53981, Dec. 10, 1976]

§ 410.511 Certification to dependent of augmentation portion of benefit.

(a) If the benefit of a miner or of a widow is augmented because of one or more dependents (see § 410.510(c)), and it appears to the Administration that the best interest of such dependent would be served thereby, the Administration may certify payment of the amount of such augmentation (to the extent attributable to such dependents) (see §§ 410.510(c) and 410.536) to such dependent directly or to a representing payee for the use and benefit of such dependent (see § 410.581ff).

(b) Any request to the Administration to certify separate payment of the amount of an augmentation in accordance with paragraph (a) of this section shall be in writing on such form and in accordance with such instructions as are prescribed by the Administration, and shall be filed with the Administration in accordance with those provisions of subpart B of this part dealing with the filing of claims as if such requests were a claim for benefits (see § 410.220(f)).

(c) In determining whether it is in the best interest of such dependent to certify separate payment of the amount of the augmentation in benefits attributable to him, the Administration shall apply the standards pertaining to representative payment in §§ 410.581 through 410.590, and the instructions issued pursuant thereto.

(d) When the Administration determines (see § 410.610(m)) that the amount of a miner's benefit attributable to the miner's wife or child should be certified for separate payment to a person other than such miner, or that the amount of a widow's benefit attributable to such widow's child should be certified for separate payment to a person other than the widow, and the miner or widow disagrees with such determination and alleges that separate certification is not in the best interest of such dependent, the Administration shall reconsider that determination (see §§ 410.622 and 410.623).

(e) Any payment made under this section, if otherwise valid under the Act, is a complete settlement and satisfaction of all claims, rights, and interests in and to such payment.

[37 FR 20647, Sept. 30, 1972]

§ 410.515 Modification of benefit amounts; general.

Under certain conditions, the amount of monthly benefits as computed in § 410.510 must be modified to determine the amount actually to be paid to a beneficiary. A modification of the amount of a monthly benefit is required in the following instances:

(a) *Reduction.* A reduction from a beneficiary's monthly benefit may be required because of:

(1) In the case of benefits to a miner, parent, brother, or sister, the excess earnings from wages and from net earnings from self-employment (see § 410.530) of such miner, parent, brother, or sister, respectively; or

(2) Failure to report earnings from work in employment and self-employment within the prescribed period of time (see § 410.530); or

(3) The receipt by a beneficiary of payments made because of the disability of the miner due to pneumoconiosis under State laws relating to workmen's compensation (including

compensation for occupational disease), unemployment compensation, or disability insurance (see § 410.520).

(4) The fact that a claim for benefits from an additional beneficiary is filed, or that such a claim is effective for a month prior to the month of filing (see § 410.535), or a dependent qualifies under subpart C of this part for an augmentation portion of the benefit of a miner or widow for a month for which another dependent has previously qualified for an augmentation (see § 410.536).

(b) *Adjustment.* An adjustment in a beneficiary's monthly benefit may be required because an overpayment or underpayment has been made to such beneficiary (see §§ 410.560, 410.570, and 410.580).

(c) *Nonpayment.* No benefits under this part are payable to the residents of a State which reduces its payments made to beneficiaries pursuant to certain State laws (see § 410.550).

(d) *Suspension.* A suspension of a beneficiary's monthly benefits may be required when the Administration has information indicating that reductions on account of the miner's excess earnings (based on criteria in section 203(b) of the Social Security Act, 42 U.S.C. 403(b)) may reasonably be expected.

(e) *''Rounding'' of benefit amounts.* Monthly benefit rates are payable in multiples of 10 cents. Any monthly benefit rate which, after all applicable computations, augmentations, and/or reductions is not a multiple of 10 cents, is increased to the next higher multiple of 10 cents. Since a fraction of a cent is not a multiple of 10 cents a benefit rate which contains such a fraction in the third decimal is raised to the next higher multiple of 10 cents.

[36 FR 23758, Dec. 14, 1971, as amended at 37 FR 20647, Sept. 30, 1972; 43 FR 34781, Aug. 7, 1978]

§ 410.520 Reductions; receipt of State benefit.

(a) As used in this section, the term *State benefit* means a payment to a beneficiary made because of the disability of the miner due to pneumoconiosis under State laws relating to workmen's compensation (including compensation for occupational disease), unemployment compensation, or disability insurance.

(b) Benefit payments to a beneficiary for a month are reduced (but not below zero) by an amount equal to any payments of State benefits received by such beneficiary for such month.

(c) Where a State benefit is paid periodically but not monthly, or in a lump sum as a commutation of or a substitute for periodic benefits, the reduction under this section is made at such time or times and in such amounts as the Administration determines will approximate as nearly as practicable the reduction required under paragraph (b) of this section. In making such a determination, a weekly State benefit is multiplied by 4⅓ and a biweekly benefit is multiplied by 2⅙, to ascertain the monthly equivalent for reduction purposes.

(d) Amounts paid or incurred, or to be incurred, by the individual for medical, legal, or related expenses in connection with his claim for State benefits (defined in paragraph (a) of this section) or the injury or occupational disease, if any, on which such award of State benefits (or settlement agreement) is based, are excluded in computing the reduction under paragraph (b) of this section, to the extent that they are consonant with State law. Such medical, legal, or related expenses may be evidenced by the State benefit award, compromise agreement, or court order in the State benefit proceedings, or by such other evidence as the Administration may require. Such other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other clear and convincing evidence indicating the amount of such expenses; or

(4) Any combination of the foregoing evidence from which the amount of such expenses may be determinable.

Any expenses not established by evidence required by the Administration will not be excluded.

[36 FR 23758, Dec. 14, 1971, as amended at 37 FR 20647, Sept. 30, 1972; 43 FR 34781, Aug. 7, 1978]

§ 410.530 Reductions; excess earnings.

Benefit payments to a miner, parent, brother, or sister are reduced by an amount equal to the deductions which would be made with respect to excess earnings under the provisions of section 203 (b), (f), (g), (h), (j), and (l) of the Social Security Act (42 U.S.C. 403 (b), (f), (g), (h), (j), and (l)), as if such benefit payments were benefits payable under section 202 of the Social Security Act (42 U.S.C. 402). (See §§ 404.428 through 404.456 of this chapter.)

[37 FR 20647, Sept. 30, 1972]

§ 410.535 Reductions; effect of an additional claim for benefits.

Beginning with the month in which a person (other than a miner) files a claim and becomes entitled to benefits, the benefits of other persons entitled to benefits with respect to the same miner, are adjusted downward, if necessary, so that no more than the permissible amount of benefits (the maximum amount for the number of beneficiaries involved) will be paid. Certain claims may also be effective retroactively for benefits for months before the month of filing (see § 410.226). For any month before the month of filing, however, otherwise correct benefits that have been previously certified by the Administration for payment to other persons with respect to the same miner may not be changed. Rather, the benefits of the person filing a claim in the later month is reduced for each month of the retroactive period to the extent that may be necessary so that the earlier and otherwise correct payment to some other person is not made erroneous. That is, for each month of the retroactive period, the amount payable to the person filing the later claim is the difference, if any, between (a) the total amount of benefits actually certified for payment to other persons for that month and (b) the permissible amount of benefits (the maximum amount for the number of beneficiaries involved) payable for that month to all persons, including the person filing later.

[37 FR 20647, Sept. 30, 1972]

§ 410.536 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.

(a) Ordinarily, a written request that the benefits of a miner or widow be augmented on account of a qualified dependent (see § 410.510(c)) is made as part of the claim for benefits filed by such miner or widow. However, it may also be made thereafter.

(b) In the latter case, beginning with the month in which such a request is filed on account of a particular dependent and in which such dependent qualifies for augmentation purposes under subpart C of this part, the augmented benefits attributable to other qualified dependents (with respect to the same miner or widow), if any, are adjusted downward, if necessary, so that the permissible amount of augmented benefits (the maximum amount for the number of dependents involved) will not be exceeded.

(c) Where, based on the entitlement to benefits of a miner or widow, a dependent would have qualified for augmentation purposes for a prior month of such miner's or widow's entitlement had such request been filed in such prior month, such request is effective for such prior month. For any month before the month of filing such request, however, otherwise correct benefits previously certified by the Administration may not be changed. Rather, the amount of the augmented benefit attributable to the dependent filing such request in the later month is reduced for each month of the retroactive period to the extent that may be necessary, so that no earlier payment for some other dependent is made erroneous. This means that for each month of the retroactive period, the amount payable to the dependent filing the later augmentation request is the difference, if any, between (1) the total amount of augmented benefits certified for payment for other dependents for that month, and (2) the permissible amount of augmented benefits (the maximum amount for the number of dependents involved) payable for that month for all dependents, including the dependent filing later.

[37 FR 20647, Sept. 30, 1972]

§ 410.540 Reductions; more than one reduction event.

If a reduction for receipt of State benefits (see § 410.520) and a reduction on account of excess earnings (see § 410.530) are chargeable to the same month, the benefit for such month is first reduced (but not below zero) by the amount of the State benefits (as determined in accordance with § 410.520(c)), and the remainder of the benefit for such month, if any, is then reduced (but not below zero) by the amount of excess earnings chargeable to such month.

§ 410.550 Nonpayment of benefits to residents of certain States.

No benefit shall be paid under this part to the residents of any State which, after December 30, 1969, reduces the benefits payable to persons eligible to receive benefits under this part, under its State laws which are applicable to its general work force with regard to workmen's compensation (including compensation for occupational disease), unemployment compensation, or disability insurance benefits which are funded in whole or in part out of employer contributions.

§ 410.560 Overpayments.

(a) *General.* As used in this subpart the term *overpayment* includes a payment where no amount is payable under part B of title IV of the Act; a payment in excess of the amount due under part B or part C of title IV of the Act; a payment resulting from the failure to reduce benefits under section 412(b) of the Act (see §§ 410.520 and 410.530); a payment to a resident of a State whose residents are not eligible for payment (see § 410.550); a payment of past due benefits to an individual where such payment had not been reduced by the amount of attorney's fees payable directly to an attorney (see § 410.686(d)); and a payment resulting from the failure to terminate benefits of an individual no longer entitled thereto. As used in this section, the term *beneficiary* includes a qualified dependent for augmentation purposes and the term *benefit* includes the amount of augmented benefits attributable to a particular dependent (see § 410.510(c)).

(b) *Overpaid beneficiary is living.* If the beneficiary to whom an overpayment was made is, at the time of a determination of such overpayment, entitled to benefits, or at any time thereafter becomes so entitled, no benefit for any month is payable to such individual, except as provided in paragraph (c) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded.

(c) *Adjustment by withholding part of a monthly benefit.* Adjustment under paragraph (b) of this section may be effected by withholding a part of the monthly benefit payable to a beneficiary where it is determined that:

(1) Withholding the full amount each month would deprive the beneficiary of income required for ordinary and necessary living expenses;

(2) The overpayment was not caused by the beneficiary's intentionally false statement or representation, or willful concealment of, or deliberate failure to furnish, material information; and

(3) Recoupment can be effected in an amount of not less than $10 a month and at a rate which would not extend the period of adjustment beyond 3 years after the initiation of the adjustment action.

(d) *Overpaid beneficiary dies before adjustment.* If an overpaid beneficiary dies before adjustment is completed under the provisions of paragraph (b) of this section, the overpayment may be recovered through—

(1) Repayment by the estate of the deceased overpaid beneficiary;

(2) Withholding benefit amounts due the estate of the deceased overpaid beneficiary;

(3) Withholding benefit amounts due any other individual because of the black lung disease of the miner; or

(4) Any combination of the methods described in this paragraph.

(Sec. 204, Social Security Act, as amended, and sec. 413, Federal Coal Mine Health and Safety Act of 1969, as amended; 49 Stat. 624, as amended and 83 Stat. 793 (42 U.S.C. 404 and 30 U.S.C. 921, 923))

[36 FR 23758, Dec. 14, 1971, as amended at 46 FR 39588, Aug. 4, 1981; 47 FR 43674, Oct. 4, 1982]

§ 410.561 Notice of right to waiver consideration.

Whenever an initial determination is made that more than the correct amount of payment has been made, and we seek adjustment or recovery of the overpayment, the individual from whom we are seeking adjustment or recovery is immediately notified. The notice includes:

(a) The overpayment amount and how and when it occurred;

(b) A request for full, immediate refund, unless the overpayment can be withheld from the next month's benefit;

(c) The proposed adjustment of benefits if refund is not received within 30 days after the date of the notice and adjustment of benefits is available;

(d) An explanation of the availability of a different rate of withholding when full withholding is proposed, installment payments when refund is requested and adjustment is not currently available, and/or cross-program recovery when refund is requested and the individual is receiving another type of payment from SSA (language about cross-program recovery is not included in notices sent to individuals in jurisdictions where this recovery option is not available);

(e) An explanation of the right to request waiver of adjustment or recovery and the automatic scheduling of a file review and pre-recoupment hearing (commonly referred to as a personal conference) if a request for waiver cannot be approved after initial paper review;

(f) An explanation of the right to request reconsideration of the fact and/or amount of the overpayment determination;

(g) Instructions about the availability of forms for requesting reconsideration and waiver;

(h) An explanation that if the individual does not request waiver or reconsideration within 30 days of the date of the overpayment notice, adjustment or recovery of the overpayment will begin;

(i) A statement that an SSA office will help the individual complete and submit forms for appeal or waiver requests; and

(j) A statement that the individual receiving the notice should notify SSA promptly if reconsideration, waiver, a lesser rate of withholding, repayment by installments or cross-program adjustment is wanted.

[61 FR 56132, Oct. 31, 1996]

§ 410.561a When waiver may be applied and how to process the request.

(a) There shall be no adjustment or recovery in any case where an overpayment under part B of title IV of the Act has been made to an individual who is without fault if adjustment or recovery would either defeat the purpose of title IV of the Act, or be against equity and good conscience.

(b) If an individual requests waiver of adjustment or recovery of an overpayment made under part B of title IV within 30 days after receiving a notice of overpayment that contains the information in § 410.561, no adjustment or recovery action will be taken until after the initial waiver determination is made. If the individual requests waiver more than 30 days after receiving the notice of overpayment, SSA will stop any adjustment or recovery actions until after the initial waiver determination is made.

(c) When waiver is requested, the individual gives SSA information to support his/her contention that he/she is without fault in causing the overpayment (see § 410.561b), and that adjustment or recovery would either defeat the purposes of this subpart (see § 410.561c) or be against equity and good conscience (see § 410.561d). That information, along with supporting documentation, is reviewed to determine if waiver can be approved. If waiver cannot be approved after this review, the individual is notified in writing and given the dates, times and place of the file review and personal conference; the procedure for reviewing the claims file prior to the personal conference; the procedure for seeking a change in the scheduled dates, times, and/or place; and all other information necessary to fully inform the individual about the personal conference. The file review is always scheduled at least 5 days before the personal conference.

(d) At the file review, the individual and the individual's representative have the right to review the claims file and applicable law and regulations with the decisionmaker or another SSA representative who is prepared to answer questions. We will provide copies of material related to the overpayment and/or waiver from the claims file or pertinent sections of the law or regulations that are requested by the individual or the individual's representative.

(e) At the personal conference, the individual is given the opportunity to:

(1) Appear personally, testify, cross-examine any witnesses, and make arguments;

(2) Be represented by an attorney or other representative (see §410.684), although the individual must be present at the conference; and

(3) Submit documents for consideration by the decisionmaker.

(f) At the personal conference, the decisionmaker:

(1) Tells the individual that the decisionmaker was not previously involved in the issue under review, that the waiver decision is solely the decisionmaker's, and that the waiver decision is based only on the evidence or information presented or reviewed at the conference;

(2) Ascertains the role and identity of everyone present;

(3) Indicates whether or not the individual reviewed the claims file;

(4) Explains the provisions of law and regulations applicable to the issue;

(5) Briefly summarizes the evidence already in file which will be considered;

(6) Ascertains from the individual whether the information presented is correct and whether he/she fully understands it;

(7) Allows the individual and the individual's representative, if any, to present the individual's case;

(8) Secures updated financial information and verification, if necessary;

(9) Allows each witness to present information and allows the individual and the individual's representative to question each witness;

(10) Ascertains whether there is any further evidence to be presented;

(11) Reminds the individual of any evidence promised by the individual which has not been presented;

(12) Lets the individual and the individual's representative, if any, present any proposed summary or closing statement;

(13) Explains that a decision will be made and the individual will be notified in writing; and

(14) Explains repayment options and further appeal rights in the event the decision is adverse to the individual.

(g) SSA issues a written decision to the individual (and his/her representative, if any) specifying the findings of fact and conclusions in support of the decision to approve or deny waiver and advising of the individual's right to appeal the decision. If waiver is denied, adjustment or recovery of the overpayment begins even if the individual appeals.

(h) If it appears that the waiver cannot be approved, and the individual declines a personal conference or fails to appear for a second scheduled personal conference, a decision regarding the waiver will be made based on the written evidence of record. Reconsideration is then the next step in the appeals process (but see §410.630(c)).

[61 FR 56132, Oct. 31, 1996]

§410.561b Fault.

Fault as used in *without fault* (see §410.561a) applies only to the individual. Although the Administration may have been at fault in making the overpayment, that fact does not relieve the overpaid individual or any other individual from whom the Administration seeks to recover the overpayment from liability for repayment if such individual is not without fault. In determining whether an individual is at fault, the Administration will consider all pertinent circumstances, including his age, intelligence, education, and physical and mental condition. What constitutes fault (except for *reduction overpayments* (see §410.561e)) on the part of the overpaid individual or on the part of any other individual from whom the Administration seeks to recover the overpayment depends upon whether the facts show that the incorrect payment to the individual resulted from:

(a) An incorrect statement made by the individual which he knew or should have known to be incorrect; or

(b) Failure to furnish information which he knew or should have known to be material; or

(c) With respect to the overpaid individual only, acceptance of a payment which he either knew or could have been expected to know was incorrect.

[37 FR 20648, Sept. 30, 1972]

§ 410.561c Defeat the purpose of title IV.

(a) *General. Defeat the purpose of title IV* for purposes of this subpart, means defeat the purpose of benefits under this title, i.e., to deprive a person of income required for ordinary and necessary living expenses. This depends upon whether the person has an income or financial resources sufficient for more than ordinary and necessary needs, or is dependent upon all of his current benefits for such needs. An individual's ordinary and necessary expenses include:

(1) Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance including premiums for supplementary medical insurance benefits under title XVIII of the Social Security Act), taxes, installment payments, etc.;

(2) Medical, hospitalization, and other similar expenses;

(3) Expenses for the support of others for whom the individual is legally responsible; and

(4) Other miscellaneous expenses which may reasonably be considered as part of the individual's standard of living.

(b) *When adjustment or recovery will defeat the purpose of title IV.* Adjustment or recovery will defeat the purposes of title IV in (but is not limited to) situations where the person from whom recovery is sought needs substantially all of his current income (including black lung benefits) to meet current ordinary and necessary living expenses.

[37 FR 20648, Sept. 30, 1972]

§ 410.561d Against equity and good conscience; defined.

Against equity and good conscience means that adjustment or recovery of an incorrect payment will be considered inequitable if an individual, because of a notice that such payment would be made or by reason of the incorrect payment, relinquished a valuable right (example 1); or changed his position for the worse (example 2). In reaching such a determination, the individual's financial circumstances are irrelevant.

Example 1. After being awarded benefits, an individual resigned from employment on the assumption he would receive regular monthly benefit payments. It was discovered 3 years later than (due to Administration error) his award was erroneous because he did not have pneumoconiosis. Due to his age, the individual was unable to get his job back, and could not get any other employment. In this situation, recovery or adjustment of the incorrect payments would be against equity and good conscience because the individual gave up a valuable right.

Example 2. A widow, having been awarded benefits for herself and daughter, entered her daughter in college because the monthly benefits made this possible. After the widow and her daughter received payments for almost a year, the deceased worker was found not to have had pneumoconiosis and all payments to the widow and child were incorrect. The widow has no other funds with which to pay the daughter's college expenses. Having entered the daughter in college and thus incurred a financial obligation toward which the benefits had been applied, she was in a worse position financially than if she and her daughter had never been entitled to benefits. In this situation, the recovery of the incorrect payments would be inequitable.

[37 FR 20648, Sept. 30, 1972]

§ 410.561e When an individual is "without fault" in a reduction-overpayment.

Except as provided in § 410.561g, or elsewhere in this subpart, an individual will be considered *without fault* in accepting a payment which is incorrect because he failed to report an event relating to excess earnings specified in section 203(b) of the Social Security Act, or which is incorrect because a reduction in his benefits equal to the amount of a deduction required under section 203(b) of the Social Security Act is necessary (see § 410.530), if it is shown that such failure to report or

such acceptance of the overpayment was due to one of the following circumstances:

(a) Reasonable belief that only his net cash earnings (''take-home'' pay) are included in determining the annual earnings limitation or the monthly earnings limitation under section 203(f) of the Social Security Act (see §410.530).

(b) Reliance upon erroneous information from an official source within the Social Security Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under part B of title IV of the Act) with respect to the interpretation of a pertinent provision of the Act or regulations pertaining thereto. For example, this circumstance could occur where the individual is misinformed by such source as to the interpretation of a provision in the Act or regulations relating to reductions.

(c) The beneficiary's death caused the earnings limit applicable to his earnings for purposes of reduction and the charging of excess earnings to be reduced below $1,680 for a taxable year.

(d) Reasonable belief that in determining, for reduction purposes, his earnings from employment and/or net earnings from self-employment in the taxable year in which he became entitled to benefits, earnings in such year prior to such entitlement would be excluded. However, this provision does not apply if his earnings in the taxable year, beginning with the first month of entitlement, exceeded the earnings limitation amount for such year.

(e) Unawareness that his earnings were in excess of the earnings limitation applicable to the imposition of reductions and the charging of excess earnings or that he should have reported such excess where these earnings were greater than anticipated because of:

(1) Retroactive increases in pay, including backpay awards;

(2) Work at a higher pay rate than realized;

(3) Failure of the employer of an individual unable to keep accurate records to restrict the amount of earnings or the number of hours worked in accordance with a previous agreement with such individual;

(4) The occurrence of five Saturdays (or other workdays, e.g., five Mondays) in a month and the earnings for the services on the fifth Saturday or other workday caused the reductions.

(f) The continued issuance of benefit checks to him after he sent notice to the Administration of the event which caused or should have caused the reductions provided that such continued issuance of checks led him to believe in good faith that he was entitled to checks subsequently received.

(g) Lack of knowledge that bonuses, vacation pay, or similar payments, constitute earnings for purposes of the annual earnings limitation.

(h) Reasonable belief that earnings in excess of the earnings limitation amount for the taxable year would subject him to reductions only for months beginning with the first month in which his earnings exceeded the earnings limitation amount. However, this provision is applicable only if he reported timely to the Administration during the taxable year when his earnings reached the applicable limitation amount for such year.

(i) Reasonable belief that earnings from employment and/or net earnings from self-employment after the attainment of age 72 in the taxable year in which he attained age 72 would not cause reductions with respect to benefits payable for months in that taxable year prior to the attainment of age 72.

(j) Reasonable belief by an individual entitled to benefits that earnings from employment and/or net earnings from self-employment after the termination of entitlement in the taxable year in which the termination event occurred would not cause reductions with respect to benefits payable for months in that taxable year prior to the month in which the termination event occurred.

(k) Failure to understand the deduction provisions of the Social Security Act or the occurrence of unusual or unavoidable circumstances the nature of which clearly shows that the individual was unaware of a violation of such reduction provisions. However, these provisions do not apply unless he made a bona fide attempt to restrict his annual earnings or otherwise comply

with the reduction provisions of the Act.

[37 FR 20648, Sept. 30, 1972]

§ 410.561f When an individual is "without fault" in an entitlement overpayment.

A benefit payment under part B of title IV of the Act to or on behalf of an individual who fails to meet one or more requirements for entitlement to such payment or the payment exceeds the amount to which he is entitled, constitutes an entitlement overpayment. Where an individual or other person on behalf of an individual accepts such overpayment because of reliance on erroneous information from an official source within the Administration (or other governmental agency which the individual had reasonable cause to believe was connected with the administration of benefits under part B of title IV of the Act) with respect to the interpretation of a pertinent provision of the Act or regulations pertaining thereto, such individual, in accepting such overpayment, will be deemed to be *without fault.*

[37 FR 20649, Sept. 30, 1972]

§ 410.561g When an individual is at "fault" in a reduction-overpayment.

(a) *Degree of care.* An individual will not be *without fault* if the Administration has evidence in its possession which shows either a lack of good faith or failure to exercise a high degree of care in determining whether circumstances which may cause reductions from his benefits should be brought to the attention of the Administration by an immediate report or by return of a benefit check. The high degree of care expected of an individual may vary with the complexity of the circumstances giving rise to the overpayment and the capacity of the particular payee to realize that he is being overpaid. Accordingly, variances in the personal circumstances and situations of individual payees are to be considered in determining whether the necessary degree of care has been exercised by an individual to warrant a finding that he was without fault in accepting a ''reduction-overpayment.''

(b) *Subsequent reduction-overpayments.* An individual will not be without fault where, after having been exonerated for a ''reduction-overpayment'' and after having been advised of the correct interpretation of the reduction provision, he incurs another ''reduction-overpayment'' under the same circumstances as the first overpayment.

[37 FR 20649, Sept. 30, 1972]

§ 410.561h When adjustment or recovery of an overpayment will be waived.

(a) *Adjustment or recovery deemed ''against equity and good conscience.''* In the situations described in §§ 410.561e (a), (b), and (c), and 410.561f, adjustment or recovery will be waived since it will be deemed such adjustment or recovery is ''against equity and good conscience.'' Adjustment or recovery will also be deemed ''against equity and good conscience'' in the situation described in § 410.561e(d), but only as to a month in which the individual's earnings from wages do not exceed the total monthly benefits affected for that month.

(b) *Adjustment or recovery considered to ''defeat the purpose of title IV'' or be ''against equity and good conscience'' under certain circumstances.* In the situation described in § 410.561e(d) (except in the case of an individual whose monthly earnings from wages in employment do not exceed the total monthly benefits affected for a particular month), and in the situations described in § 410.561e (e) through (k), adjustment or recovery shall be waived only where the evidence establishes that adjustment or recovery would work a financial hardship (see § 410.561c) or would otherwise be inequitable (see § 410.561d).

[37 FR 20649, Sept. 30, 1972]

§ 410.563 Liability of a certifying officer.

No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any individual:

(a) Where adjustment or recovery of such amount is waived under section 204(b) of the Social Security Act; or

(b) Where adjustment under section 204(a) of the Social Security Act is not

completed prior to the death of all individuals against whose benefits or lump sums reductions are authorized; or

(c) Where a claim for recovery of an overpayment is compromised or collection or adjustment action is suspended or terminated pursuant to the Federal Claims Collection Act of 1966 (31 U.S.C. 951–953) (see § 410.565).

[37 FR 20649, Sept. 30, 1972]

§ 410.565 Collection and compromise of claims for overpayment.

(a) *General effect of the Federal Claims Collection Act of 1966.* Claims by the Administration against an individual for recovery of overpayments under part B of title IV of the Act, not exceeding the sum of $20,000, exclusive of interest, may be compromised, or collection suspended or terminated where such individual or his estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section) or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section) except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension or termination of collection of a claim for overpayment*—(1) *Overpaid individual alive.* In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having an interest in the claim.

(2) *Overpaid individual deceased.* In any case where the overpaid individual is deceased (i) a claim for overpayment in excess of $5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication of fraud: The filing of a false claim, or misrepresentation on the part of such deceased individual, and (ii) a claim for overpayment regardless of the amount will not be compromised, nor will there be suspension or termination of collection of the claim by the Administration if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under part B of title IV of the Act, the Administration will consider such individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property, savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Administration will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Administration will consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under part B of title IV of the Act would not justify enforced collection proceedings for the full amount of the claim or there is doubt concerning the Administration's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount will be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under part B of title IV of the Act shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings giving due consideration to the exemptions available to the overpaid individual under State or Federal law and the time which such collection will take.

(f) *Payment.* Payment of the amount which the Administration has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under part B of title IV of the Act must be made within the time and in the manner set by the Administration. A claim for such recovery of

the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Administration. Failure of the overpaid individual or his estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

§ 410.570 Underpayments.

(a) *General.* As used in this subpart, the term *underpayment* includes a payment in an amount less than the amount of the benefit due for such month, and nonpayment where some amount of such benefits are payable.

(b) *Underpaid individual is living.* If an individual to whom an underpayment is due is living, the amount of such underpayment will be paid to such individual either in a single payment (if he is not entitled to a monthly benefit) or by increasing one or more monthly benefit payments to which such individual is or becomes entitled.

(c) *Underpaid individual dies before adjustment of underpayment.* If an individual to whom an underpayment is due dies before receiving payment or negotiating a check or checks representing such payment, such underpayment will be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse who was either:

(i) Living in the same household (as defined in § 410.393) with the deceased individual at the time of such individual's death, or

(ii) In the case of a deceased miner, entitled for the month of death to widow's black lung benefits.

(2) In the case of a deceased miner or widow, his or her child entitled to benefits as the surviving child of such miner or widow for the month in which such miner or widow died (if more than one such child, in equal shares to each such child). As used in this subparagraph, ''entitled to benefits as a surviving child'' refers to the benefit described in § 410.212, and not to the payment described in § 410.510(c).

(3) In the case of a deceased miner, his parent entitled to benefits as the surviving parent of such miner for the month in which such miner died (if more than one such parent, in equal shares to each such parent).

(4) The surviving spouse of the deceased individual who does not qualify under paragraph (c)(1) of this section.

(5) The child or children of the deceased individual who do not qualify under paragraph (c)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual who do not qualify under paragraph (c)(3) of this section (if more than one such parent, in equal shares to each such parent).

(7) The legal representative of the estate of the deceased individual as defined in paragraph (e) of this section.

(d) *Person qualified to receive underpayment dies before receiving payment.* In the event that a person who is otherwise qualified to receive an underpayment under the provisions of paragraph (c) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his share of the underpayment will be divided among the remaining living person(s) in the same order of priority. In the event that there is (are) no other such person(s), the underpayment will be paid to the living person(s) in the next lower order of priority under paragraph (c) of this section.

(e) *Definition of legal representative.* The term *legal representative,* for the purpose of qualifying to receive an underpayment, generally means the executor or the administrator of the estate of the deceased beneficiary. However, it may also include an individual, institution, or organization acting on behalf of an unadministered estate: *Provided,* The person can give the Administration good acquittance (as defined in paragraph (f) of this section). The following persons may qualify as legal representative for purposes of this section, provided they can give the Administration good acquittance:

(1) A person who qualifies under a State's ''small estate'' statute; or

(2) A person resident in a foreign country who, under the laws and customs of that country, has the right to receive assets of the estate; or

(3) A public administrator; or

(4) A person who has the authority, under applicable law, to collect the assets of the estate of the deceased beneficiary.

(f) *Definition of good acquittance.* A person is considered to give the Admini- stration *good acquittance* when payment to that person will release the Administration from further liability for such payment.

[36 FR 23758, Dec. 14, 1971, as amended at 37 FR 20650, Sept. 30, 1972]

§ 410.580 Relation to provisions for reductions or increases.

The amount of an overpayment or underpayment is the difference between the amount actually paid to the beneficiary and the amount of the payment to which the beneficiary was actually entitled. Such overpayment or underpayment, for example, would be equal to the difference between the amount of a benefit in fact paid to the beneficiary and the amount of such benefit as reduced under section 412(b) of the Act, as increased pursuant to section 412(a)(1), or as augmented under section 412(a)(3), of the Act. In effecting an adjustment with respect to an overpayment, no amount can be considered as having been withheld from a particular benefit which is in excess of the amount of such benefit as so reduced. Overpayments and underpayments simultaneously outstanding on account of the same beneficiary are first adjusted against one another before adjustment pursuant to the other provisions of this subpart.

§ 410.581 Payments on behalf of an individual.

When it appears to the Administration that the interest of a beneficiary entitled to a payment under part B of title IV of the Act would be served thereby, certification of payment may be made by the Administration, regardless of the legal competency or incompetency of the beneficiary entitled thereto, either for direct payment to such beneficiary, or for his use and benefit to a relative or some other person as the ''representative payee'' of the beneficiary. When it appears that an individual who is receiving benefit payments may be incapable of managing such payments in his own interest, the Administration shall, if such individual is age 18 or over and has not been adjudged legally incompetent, continue payments to such individual pending a determination as to his capacity to manage benefit payments and the selection of a representative payee. As used in §§ 410.581 through 410.590, the term *beneficiary* includes the dependent of a miner or widow who could qualify for certification of separate payment of an augmentation portion of such miner's or widow's benefits (see §§ 410.510(c) and 410.511).

[37 FR 20650, Sept. 30, 1972]

§ 410.582 Submission of evidence by representative payee.

Before any amount shall be certified for payment to any relative or other person as representative payee for and on behalf of a beneficiary, such relative or other person shall submit to the Administration such evidence as it may require of his relationship to, or his responsibility for the care of, the beneficiary on whose behalf payment is to be made, or of his authority to receive such payment. The Administration may, at any time thereafter, require evidence of the continued existence of such relationship, responsibility, or authority. If any such relative or other person fails to submit the required evidence within a reasonable period of time after it is requested, no further payments shall be certified to him on behalf of the beneficiary unless for good cause shown, the default of such relative or other person is excused by the Administration, and the required evidence is thereafter submitted.

[37 FR 20650, Sept. 30, 1972]

§ 410.583 Responsibility of representative payee.

A relative or other person to whom certification of payment is made on behalf of a beneficiary as representative payee shall, subject to review by the Administration and to such requirements as it may from time to time prescribe, apply the payments certified to him on behalf of a beneficiary only for the use and benefit of such beneficiary

in the manner and for the purposes determined by him to be in the beneficiary's best interest.

[37 FR 20650, Sept. 30, 1972]

§ 410.584 Use of benefits for current maintenance.

Payments certified to a relative or other person on behalf of a beneficiary shall be considered as having been applied for the use and benefit of the beneficiary when they are used for the beneficiary's current maintenance. Where a beneficiary is receiving care in an institution (see § 410.586), current maintenance shall include the customary charges made by the institution to individuals it provides with care and services like those it provides the beneficiary and charges made for current and foreseeable needs of the beneficiary which are not met by the institution.

[37 FR 20650, Sept. 30, 1972]

§ 410.585 Conservation and investment of payments.

Payments certified to a relative or other person on behalf of a beneficiary which are not needed for the current maintenance of the beneficiary except as they may be used pursuant to § 410.587, shall be conserved or invested on the beneficiary's behalf. Preferred investments are U.S. Savings Bonds, but such funds may also be invested in accordance with the rules applicable to investment of trust estates by trustees. For example, surplus funds may be deposited in an interest- or dividend-bearing account in a bank or trust company, in a savings and loan association, or in a credit union, if the account is either federally insured or is otherwise insured in accordance with State law requirements. Surplus funds deposited in an interest- or dividend-bearing account in a bank or trust company, in a savings and loan association, or in a credit union, must be in a form of account which clearly shows that the representative payee has only a fiduciary, and not a personal, interest in the funds. The preferred forms of such accounts are as follows:

(Name of beneficiary) by , (Name of representative payee) representative payee; or

(Name of beneficiary) by , (Name of representative payee) trustee.

U.S. Savings Bonds purchased with surplus funds by a representative payee for a minor should be registered as follows:

(Name of beneficiary) (Social Security No.), a minor, for whom (Name of payee) is representative payee for black lung benefits.

U.S. Savings Bonds purchased with surplus funds by a representative payee for an incapacitated adult beneficiary should be registered as follows:

, (Name of beneficiary) (Social Security No.), for whom (Name of payee) is representative payee for black lung benefits.

A representative payee who is the legally appointed guardian or fiduciary of the beneficiary may also register U.S. Savings Bonds purchased with funds from the payment of benefits under part B of title IV in accordance with applicable regulations of the U.S. Treasury Department (31 CFR 315.5 through 315.8). Any other approved investment of the beneficiary's funds made by the representative payee must clearly show that the payee holds the property in trust for the beneficiary.

[41 FR 17892, Apr. 29, 1976]

§ 410.586 Use of benefits for beneficiary in institution.

Where a beneficiary is confined in a Federal, State, or private institution because of mental or physical incapacity, the relative or other person to whom payments are certified on behalf of the beneficiary shall give highest priority to expenditure of the payments for the current maintenance needs of the beneficiary, including the customary charges made by the institution (see § 410.584) in providing care and maintenance. It is considered in the best interest of the beneficiary for the relative or other person to whom payments are certified on the beneficiary's behalf to allocate expenditure of the payments so certified in a manner which will facilitate the beneficiary's earliest possible rehabilitation or release from the institution or which otherwise will help him live as normal a life as practicable in the institutional environment.

[37 FR 20651, Sept. 30, 1972]

§410.587 Support of legally dependent spouse, child, or parent.

If current maintenance needs of a beneficiary are being reasonably met, a relative or other person to whom payments are certified as representative payee on behalf of the beneficiary may use part of the payment so certified for the support of the legally dependent spouse, a legally dependent child, or a legally dependent parent of the beneficiary.

[37 FR 20651, Sept. 30, 1972]

§410.588 Claims of creditors.

A relative or other person to whom payments under part B of title IV of the Act are certified as representative payee on behalf of a beneficiary may not be required to use such payments to discharge an indebtedness of the beneficiary which was incurred before the first month for which payments are certified to a relative or other person on the beneficiary's behalf. In no case, however, may such payee use such payments to discharge such indebtedness of the beneficiary unless the current and reasonably foreseeable future needs of the beneficiary are otherwise provided for.

[37 FR 20651, Sept. 30, 1972]

§410.589 Accountability.

A relative or other person to whom payments are certified as representative payee on behalf of a beneficiary shall submit a written report in such form and at such times as the Administration may require, accounting for the payments certified to him on behalf of the beneficiary unless such payee is a court-appointed fiduciary and, as such, is required to make an annual accounting to the court, in which case a true copy of each such account filed with the court may be submitted in lieu of the accounting form prescribed by the Administration. If any such relative or other person fails to submit the required accounting within a reasonable period of time after it is requested, no further payments shall be certified to him on behalf of the beneficiary unless for good cause shown, the default of such relative or other person is excused by the Administration, and the required accounting is thereafter submitted.

[37 FR 20651, Sept. 30, 1972]

§410.590 Transfer of accumulated benefit payments.

A representative payee who has conserved or invested funds from payments under part B of title IV of the Act certified to him on behalf of a beneficiary shall, upon direction of the Administration, transfer any such funds (including interest earned from investment of such funds) to a successor payee appointed by the Administration, or, at the option of the Administration, shall transfer such funds, including interest, to the Administration for recertification to a successor payee or to the beneficiary.

[37 FR 20651, Sept. 30, 1972]

§410.591 Eligibility for services and supplies under part C of title IV of the act.

The Social Security Administration will notify each miner entitled to benefits on the basis of a claim filed under part B of the title IV of the Act of his or her possible eligibility for medical services and supplies under part C of title IV of the Act. Application for medical benefits under part C will not jeopardize a person's eligibility for part B benefits, regardless of the outcome of the claim for part C benefits. The DOL regulations covering the time period in which the miner must file with DOL for these benefits are published at 20 CFR part 725.

(Sec. 411, Federal Coal Mine Health and Safety Act of 1969, as amended; 85 Stat. 793, 30 U.S.C. 921)

[43 FR 34781, Aug. 7, 1978]

Subpart F—Determinations of Disability, Other Determinations, Administrative Review, Finality of Decisions, and Representation of Parties

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)); 30 U.S.C. 923(b), 936(a), 956, and 957.

SOURCE: 36 FR 23760, Dec. 14, 1971, unless otherwise noted.

§ 410.601 Determinations of disability.

(a) *By State agencies.* In any State which has entered into an agreement with the Commissioner to provide determinations as to whether a miner is under a total disability (as defined in § 410.412) due to pneumoconiosis (as defined in § 410.110(n)). Determinations as to the date total disability began, and as to the date total disability ceases, shall be made by the State agency or agencies designated in such agreement on behalf of the Commissioner for all individuals in such State, or for such class or classes of individuals in the State as may be designated in the agreement.

(b) *By the Administration.* Determinations as to whether a miner is under a total disability (as defined in § 410.412) due to pneumoconiosis (as defined in § 410.110(n)), as to the date the total disability began, and as to the date the total disability ceases, shall be made by the Administration on behalf of the Commissioner. The Administration shall make such determinations for individuals in any State which has not entered into an agreement to make such determinations, for any class or classes of individuals to which such an agreement is not applicable, or for any individuals outside the United States. In addition, all other determinations as to entitlement to and the amounts of benefits shall be made by the Administration on behalf of the Commissioner.

(c) *Review by Administration of State agency determinations.* The Administration may review a determination made by a State agency that a miner is under a total disability and, as a result of such review, may determine that such individual is not under a total disability, or that the total disability began on a date later than that determined by the State agency, or that the total disability ceased on a date earlier than that determined by the State agency.

(d) *Initial determinations as to entitlement or termination of entitlement.* After any determination as to whether an individual is under a total disability or has ceased to be under a total disability, the Administration shall make an initial determination (see § 410.610) with respect to entitlement to benefits.

(e) *Simultaneous claims.* The adjudication of any claim under this part shall not be delayed for the adjudication of any other benefit claim by the same individual pending before the Administration.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 20651, Sept. 30, 1972; 62 FR 38453, July 18, 1997; 65 FR 16814, Mar. 30, 2000]

§ 410.610 Administrative actions that are initial determinations.

(a) *Entitlement to benefits.* The Administration, subject to the limitations of a Federal-State agreement pursuant to section 413(b) of the Act (see § 410.601 (a)), shall make findings, setting forth the pertinent facts and conclusions, and an initial determination with respect to entitlement to benefits of any individual who has filed a claim for benefits. The determination shall include the amount, if any, to which the individual is entitled and, where applicable, such amount as reduced (see § 410.515), augmented or otherwise increased (see § 410.510).

(b) *Modification of the amount of benefits.* The Administration shall, under the circumstances hereafter stated in this paragraph, make findings, setting forth the pertinent facts and conclusions, and an initial determination as to whether:

(1) There should be a reduction under section 412(b) (or section 412(a)(5)) of the Act, and if a reduction is to be made, the amount thereof (see § 410.515(a)); or

(2) There has been an overpayment (see § 410.560) or an underpayment (see § 410.570) of benefits and, if so, the amount thereof, and the adjustment to be made by increasing or decreasing the monthly benefits to which a beneficiary is entitled (see § 410.515(b)), and,in the case of an underpayment due a deceased beneficiary, the person to whom the underpayment should be paid.

(c) *Termination of benefits.* The Administration, subject to the limitations of a Federal-State agreement pursuant to section 413(b) of the Act (see § 410.601 (a)), shall, with respect to a beneficiary who has been determined to be entitled to benefits, make findings, setting forth the pertinent facts

and conclusions, and an initial determination as to whether, under the applicable provisions of part B of title IV of the Act, such beneficiary's entitlement to benefits has ended and, if so, the effective date of such termination.

(d) *Reinstatement of benefits.* The Administration shall, with respect to a beneficiary whose benefits have been determined to have ended under paragraph (c) of this section, make findings, setting forth the pertinent facts and conclusions, and an initial determination as to whether the individual is entitled to a reinstatement of benefits thus ended, and if so, the effective date of such reinstatement. Such findings of fact and determination shall be made whenever a party makes a written request for reinstatement or whenever evidence is received which justifies such reinstatement (see for example §§410.671 through 410.673).

(e) *Augmentation of benefits.* The Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination, as to whether a beneficiary has or continues to have dependents who, at the appropriate time, qualify under the relationship, dependency, and other applicable requirements of subpart C of this part, for purposes of entitling such beneficiary to an augmentation of his benefits pursuant to §410.510(b).

(f) *Other increases in benefit amounts.* The Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination, as to whether a beneficiary is entitled to an increase in benefits (other than an augmentation) pursuant to section 412(a) of the Act.

(g) *Applicant's failure to submit evidence.* If an individual fails to submit in support of his claim for benefits or request for augmentation or other increase of benefits, such evidence as may be requested by the Administration pursuant to §410.240 or any provision of the Act, the Administration may make an initial determination disallowing the individual's claim or his request for such augmentation or other increase. The initial determination, however, shall specify the conditions of entitlement to benefits or to an augmentation or other increase of benefits that the individual has failed to satisfy because of his failure to submit the requested evidence (see §410.240).

(h) *Failure to file or prosecute claim under applicable State workmen's compensation law.* The Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination, as to whether an individual has failed to file or to prosecute a claim under the applicable State workmen's compensation law pursuant to §410.219.

(i) *Withdrawal of claim or cancellation of withdrawal request.* When a request for withdrawal of a claim, or a request for cancellation of a ''request for withdrawal'' of a claim, is denied by the Administration, the Administration shall make findings setting forth the pertinent facts and conclusions and an initial determination of denial.

(j) *Request for reimbursement for medical expenses—amount in controversy $100 or more.* The Administration shall, with respect to a claimant who requests reimbursement for medical expenses (see §410.240(h)), make findings, setting forth the pertinent facts and conclusions and, where the amount in controversy is $100 or more, an initial determination as to whether and the extent to which the expenses for which the reimbursement request is made are medical expenses reasonably incurred by the claimant in establishing his claim. (Also see §410.615(e).)

(k) *Waiver of adjustment or recovery of monthly benefits.* The Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination as to whether there shall be no adjustment or recovery where an overpayment with respect to an individual has been made (see §410.561).

(l) *Need for representative payment.* The Social Security Administration shall make findings, setting forth the pertinent facts and conclusions and an initial determination in accordance with section 205(j) of the Social Security Act (42 U.S.C. 405(j)), as to:

(1) Whether representative payment shall serve the interests of an individual by reason of his incapacity to manage his benefit payments (see §410.581) except that findings as to incapacity with respect to an individual

under age 18 or with respect to an individual adjudged legally incompetent shall not be considered initial determinations; and,

(2) Who shall be appointed or continued as representative payee on behalf of a beneficiary under this part.

(m) *Separate certification of payment to dependent.* Where the benefit of a miner or of a widow is increased (''augmented'') because he or she has a qualified dependent (see § 410.510(c)), and it appears to the Administration that it would be in the best interest of any such dependent to have the amount of the augmentation (to the extent attributable to such dependent) certified separately to such dependent (see § 410.511(a)) or to a representative payee on his behalf (see § 410.581), the Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination, as to whether separate payment of an augmented amount should be certified (see § 410.511(a)).

(n) *Support of parent, brother, or sister.* The Administration shall make findings, setting forth the pertinent facts and conclusions, and an initial determination, as to whether a parent, brother, or sister, meets the requirements for support from the miner set forth in the pertinent provisions of section 412(a)(5) of the Act and whether proof of support was submitted to the Administration within the time limits set forth in the Act or under the provisions described in § 410.214(d).

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 20651, Sept. 30, 1972; 41 FR 30114, July 22, 1976]

§ 410.615 Administrative actions that are not initial determinations.

Administrative actions which shall not be considered initial determinations, but which may receive administrative review include, but are not limited to, the following:

(a) The suspension of benefits pursuant to the criteria in section 203(h)(3) of the Social Security Act (42 U.S.C. 403 (h)(3)), pending investigation and determination of any factual issue as to the applicability of a reduction under section 412(b) of the Act equivalent to the amount of a deduction because of excess earnings under section 203(b) of the Social Security Act (42 U.S.C. 403(b)) (see §§ 410.515(d) and 410.530).

(b) The denial of an application to be made representative payee for and on behalf of a beneficiary under part B of title IV of the Act (see § 410.581).

(c) The certification of any two or more individuals of the same family for joint payment of the total benefits payable to such individuals (see § 410.505).

(d) The withholding by the Administration in any month, for the purpose of recovering an overpayment, of less than the full amount of benefits otherwise payable in that month (see § 410.560(c)).

(e) The authorization approving or regulating the amount of the fee that may be charged or received by a representative for services before the Administration (see § 410.686b(e)).

(f) The disqualification or suspension of an individual from acting as a representative in a proceeding before the Administration (see § 410.688).

(g) The determination by the Administration under the authority of the Federal Claims Collection Act (31 U.S.C. 951–953) not to compromise a claim for overpayment under part B of title IV of the Act, or not to suspend or terminate collection of such a claim, or the determination to compromise such a claim, including the compromise amount and the time and manner of payment (see § 410.565).

(h) Where the amount in controversy is less than $100, the denial of a request for reimbursement of medical expenses (see § 410.240(h)) which are claimed to have been incurred by the claimant in establishing his claim for benefits, or the approval of such request for reimbursement in an amount less than the amount requested. (Also see § 410.610(j).)

(i) The determination by the Social Security Administration that an individual is not qualified for use of the expedited appeals process, as provided in § 410.629a.

(j) The denial by the Administration of a request to readjudicate a claim and apply an Acquiescence Ruling.

[37 FR 20651, Sept. 30, 1972, as amended at 40 FR 53387, Nov. 18, 1975; 41 FR 30114, July 22, 1976; 55 FR 1019, Jan. 11, 1990]

§ 410.620 Notice of initial determination.

Written notice of an initial determination shall be mailed to the party to the determination at his last known address, except that no such notice shall be required in the case of a determination that a party's entitlement to benefits has ended because of such party's death (see § 410.610(c)). If the initial determination disallows, in whole or in part, the claim of a party, or if the initial determination is to the effect that a party's entitlement to benefits has ended, or that a reduction or adjustment is to be made in benefits, the notice of the determination sent to the party shall state the specific reasons for the determination. Such notice shall also inform the party of the right to reconsideration (see § 410.623). Where more than the correct amount of payment has been made, see § 410.561.

[37 FR 20652, Sept. 30, 1972]

§ 410.621 Effect of initial determination.

The initial determination shall be final and binding upon the party or parties to such determination unless it is reconsidered in accordance with §§ 410.623 through 410.629, or it is revised in accordance with § 410.671.

§ 410.622 Reconsideration and hearing.

Any party who is dissatisfied with an initial determination may request that the Administration reconsider such determination, as provided in § 410.623. If a request for reconsideration is filed, such action shall not constitute a waiver of the right to a hearing subsequent to such reconsideration if the party requesting such reconsideration is dissatisfied with the determination of the Administration made on such reconsideration; and a request for a hearing may thereafter be filed, as is provided in § 410.630.

§ 410.623 Reconsideration; right to reconsideration.

(a) We shall reconsider an initial determination if a written request for reconsideration is filed, as provided in § 410.624, by or for the party to the initial determination (see § 410.610). We shall also reconsider an initial determination if a written request for reconsideration is filed, as provided in § 410.624, by an individual as a widow, child, parent, brother, sister, or representative of a decedent's estate, who makes a showing in writing that his or her rights with respect to benefits may be prejudiced by such determination.

(b) Reconsideration is the first step in the administrative review process that we provide for an individual dissatisfied with the initial determination, except that we provide the opportunity for a hearing before an administrative law judge as the first step for those situations described in §§ 410.630 (b) and (c), where an individual appeals an initial determination denying waiver of adjustment or recovery of an overpayment (see § 410.561a).

[61 FR 56133, Oct. 31, 1996]

§ 410.624 Time and place of filing request.

The request for reconsideration shall be made in writing and filed at an office of the Social Security Administration within 60 days after the date of receipt of notice of the initial determination, unless such time is extended as specified in § 410.668. For purposes of this section, the date of receipt of notice of the initial determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary.

[41 FR 47918, Nov. 1, 1976]

§ 410.625 Parties to the reconsideration.

The parties to the reconsideration shall be the person who was the party to the initial determination (see § 410.610) and any other person referred to in § 410.623 upon whose request the initial determination is reconsidered.

§ 410.626 Notice of reconsideration.

If the request for reconsideration is filed by a person other than the party to the initial determination, the Administration shall, before such reconsideration, mail a written notice to such party at his last known address, informing him that the initial determination is being reconsidered. In addition, the Administration shall give such party a reasonable opportunity to

present such evidence and contentions as to fact or law as he may desire relative to the determination.

§ 410.627 Reconsidered determination.

When a request for reconsideration has been filed, as provided in §§ 410.623 and 410.624, the Administration or the State agency, as appropriate (see § 410.601), shall reconsider the determination with respect to disability or the initial determination in question and the findings upon which it was based; and upon the basis of the evidence considered in connection with the initial determination and whatever other evidence is submitted by the parties or is otherwise obtained, the Administration shall make a reconsidered determination affirming or revising, in whole or in part, the findings and determination in question.

§ 410.628 Notice of reconsidered determination.

Written notice of the reconsidered determination shall be mailed by the Social Security Administration to the parties at their last known addresses. The reconsidered determination shall state the specific reasons therefor and inform the parties of their right to a hearing (see § 410.630), or, if appropriate, inform the parties of the requirements for use of the expedited appeals process (see § 410.629a).

[40 FR 53387, Nov. 18, 1975]

§ 410.629 Effect of a reconsidered determination.

The reconsidered determination shall be final and binding upon all parties to the reconsideration unless a hearing is requested in accordance with § 410.631 and a decision rendered or unless such determination is revised in accordance with § 410.671, or unless the expedited appeals process is used in accordance with § 410.629a.

[40 FR 53388, Nov. 18, 1975]

§ 410.629a Expedited appeals process; conditions for use of such process.

In cases in which a reconsideration determination has been made or a higher level of appeal has been reached, an expedited appeals process may be used in lieu of the hearing and Appeals Council review, if the following conditions are met:

(a) A reconsideration determination has been made by the Commissioner; and

(b) The individual is a party referred to in § 410.629c; and

(c) The individual has filed a written request for the expedited appeals process; and

(d) The individual has alleged, and the Commissioner agrees, that the only factor precluding a favorable determination with respect to a matter referred to in § 410.610, is a statutory provision which the individual alleges to be unconstitutional; and

(e) Where more than one individual is a party referred to in § 410.629c, each and every party concurs in the request for the expedited appeals process.

[40 FR 53388, Nov. 18, 1975, as amended at 62 FR 38453, July 18, 1997]

§ 410.629b Expedited appeals process; place and time of filing request.

(a) *Place of filing request.* The request for the expedited appeals process must be made in writing and filed:

(1) At an office of the Social Security Administration; or

(2) With a presiding officer.

(b) *Time of filing request.* The request for the expedited appeals process must be filed at one of the following times:

(1) No later than 60 days after the date of receipt of notice of the reconsidered determination, unless the time is extended in accordance with the standards set out in § 410.669 of this chapter. For purposes of this paragraph, the date of receipt of notice of the reconsidered determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary; or

(2) If a request for hearing has been timely filed (see § 410.631), at any time prior to the individual's receipt of notice of the presiding officer's decision; or

(3) Within 60 days after the date of receipt of notice of the presiding officer's decision or dismissal, unless the time is extended in accordance with the standards set out in § 410.669 of this chapter. For purposes of this paragraph (b)(3), the date of receipt of notice of

the presiding officer's decision or dismissal shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary; or

(4) If a request for review by the Appeals Council has been timely filed (see §410.661), at any time prior to receipt by such individual of notice of the Appeals Council's final action.

[40 FR 53388, Nov. 18, 1975, as amended at 41 FR 47918, Nov. 1, 1976]

§410.629c Expedited appeals process; parties.

The parties to the expedited appeals process shall be the person or persons who were parties to the reconsideration determination in question and, if appropriate, parties to the hearing.

[40 FR 53388, Nov. 18, 1975]

§410.629d Expedited appeals process; agreement requirements.

(a)(1) An authorized representative of the Commissioner shall, if he determines that all conditions for the use of the expedited appeals process are met (see §410.629), prepare an agreement for signature of the party (parties) and an authorized representative of the Commissioner.

(2)(i) Where a request for hearing has been filed, but prior to issuance of a decision a request for the expedited appeals process is filed, the Chief Administrative Law Judge of the Bureau of Hearings and Appeals, or his designee, shall determine if the conditions required for entering an agreement are met.

(ii) Where a hearing decision was the last action, or where a request for review is pending before the Appeals Council, and a request for the expedited appeals process is filed, the Chairman or Deputy Chairman of the Appeals Council, or the Chairman's designee, shall determine if the conditions required for an agreement are met.

(b) An agreement with respect to the expedited appeals process shall provide that:

(1) The facts involved in the claim are not in dispute; and

(2) Except as indicated in paragraph (b)(3) of this section, the Commissioner's interpretation of the law is not in dispute; and

(3) The sole issue(s) in dispute is the application of a statutory provision(s) which is described therein and which is alleged to be unconstitutional by the party requesting use of such process; and

(4) Except for the provision challenged, the right(s) of the party is established; and

(5) The determination or decision made by the Commissioner is final for purposes of section 205(g) of the Act.

[40 FR 53388, Nov. 18, 1975, as amended at 62 FR 38453, July 18, 1997]

§410.629e Expedited appeals process; effect of agreement.

The agreement described in §410.629d, when signed, shall constitute a waiver by the parties and the Commissioner with respect to the need of the parties to pursue the remaining steps of the administrative appeals process, and the period for filing a civil action in a district court of the United States, as provided in section 205(g) of the Social Security Act, shall begin as of the date of receipt of notice by the party (parties) that the agreement has been signed by the authorized representative of the Commissioner. Any civil action under the expedited appeals process must be filed within 60 days after the date of receipt of notice (a signed copy of the agreement will be mailed to the party (parties) and will constitute notice) that the agreement has been signed by the Commissioner's authorized representative. For purposes of this section, the date of receipt of notice of signing shall be presumed to be 5 days after the date of the notice, unless there is a reasonable showing to the contrary.

[49 FR 46369, Nov. 26, 1984, as amended at 62 FR 38453, July 18, 1997]

§410.629f Effect of a request that does not result in agreement.

If a request for the expedited appeals process does not meet all the conditions for the use of the process, the Commissioner shall so advise the party (parties) and shall treat the request as

a request for reconsideration, a hearing, or Appeals Council review, whichever is appropriate.

[40 FR 53388, Nov. 18, 1975, as amended at 62 FR 38453, July 18, 1997]

§ 410.630 Hearing; right to hearing.

An individual referred to in § 410.632 or § 410.633 who has filed a written request for a hearing under the provisions in § 410.631 has a right to a hearing if:

(a) An initial determination and reconsideration of the determination have been made by the Social Security Administration concerning a matter designated in § 410.610;

(b) An initial determination denying waiver of adjustment of recovery of an overpayment based on a personal conference has been made by the Social Security Administration (see § 410.561a); or

(c) An initial determination denying waiver of adjustment or recovery of an overpayment based on a review of the written evidence of record has been made by the Social Security Administration (see § 410.561a) and the determination was made concurrent with, or subsequent to, our reconsideration determination regarding the underlying overpayment but before an administrative law judge holds a hearing.

[61 FR 56133, Oct. 31, 1996]

§ 410.631 Time and place of filing request.

The request for hearing shall be made in writing and filed at an office of the presiding officer, or the Appeals Council. Except where the time is extended as provided in § 410.669, the request for hearing must be filed:

(a) Within 60 days after the date of receipt of notice of the reconsidered determination by such individual. For purposes of this section, the date of receipt of notice of the reconsidered determinations shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary; or

(b) Where an effective date (not more than 30 days later than the date of mailing) is expressly indicated in such notice, within 60 days after such effective date.

[41 FR 47918, Nov. 1, 1976]

§ 410.632 Parties to a hearing.

The parties to a hearing shall be the person or persons who were parties to the initial determination in question and the reconsideration. Any other individual may be made a party if such individual's rights with respect to benefits may be prejudiced by the decision, upon notice given to him by the Administrative Law Judge to appear at the hearing or otherwise present such evidence and contentions as to fact or law as he may desire in support of his interest.

§ 410.633 Additional parties to the hearing.

The following individuals, in addition to those named in § 410.632, may also be parties to the hearing. A widow, child, parent, brother, sister, or representative of a decedent's estate, who makes a showing in writing that such individual's rights with respect to benefits may be prejudiced by any decision that may be made, may be a party to the hearing.

[37 FR 20652, Sept. 30, 1972]

§ 410.634 Administrative Law Judge.

The hearing provided for in this subpart F shall, except as herein provided, be conducted by an Administrative Law Judge designated by the Deputy Commissioner for Programs and Policy, or his or her designee. In an appropriate case, the Deputy Commissioner may designate another Administrative Law Judge or a member or members of the Appeals Council to conduct a hearing, in which case the provisions of this subpart F governing the conduct of a hearing by an Administrative Law Judge shall be applicable thereto.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38453, July 18, 1997]

§ 410.635 Disqualification of Administrative Law Judge.

No Administrative Law Judge shall conduct a hearing in a case in which he is prejudiced or partial with respect to any party, or where he has any interest

in the matter pending for decision before him. Notice of any objection which a party may have to the Administrative Law Judge who will conduct the hearing, shall be made by such party at his earliest opportunity. The Administrative Law Judge shall consider such objection and shall, in his discretion, either proceed with the hearing or withdraw. If the Administrative Law Judge withdraws, another Administrative Law Judge shall be designated by the Deputy Commissioner for Programs and Policy, or his or her designee to conduct the hearing. If the Administrative Law Judge does not withdraw, the objecting party may, after the hearing, present his objections to the Appeals Council, as provided in §§ 410.660 through 410.664 as reasons why the Administrative Law Judge's decision should be revised or a new hearing held before another Administrative Law Judge.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38453, July 18, 1997]

§ 410.636 Time and place of hearing.

The Administrative Law Judge (formerly called ''hearing examiner'') shall fix a time and a place within the United States for the hearing, written notice of which, unless waived by a party, shall be mailed to the parties at their last known addresses or given to them by personal service, not less than 10 days prior to such time. As used in this section and in § 410.647, the United States means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the Virgin Islands. Written notice of the objections of any party to the time and place fixed for a hearing shall be filed by the objecting party with the Administrative Law Judge at the earliest practicable opportunity (before the time set for such hearing). Such notice shall state the reasons for the party's objection and his choice as to the time and place within the United States for the hearing. The Administrative Law Judge may, for good cause, fix a new time and/or place within the United States for the hearing.

[37 FR 20652, Sept. 30, 1972]

§ 410.637 Hearing on new issues.

At any time after a request for hearing has been made, as provided in § 410.631, but prior to the mailing of notice of the decision, the Administrative Law Judge may, in his discretion, either on the application of a party or his own motion, in addition to the matters brought before him by the request for hearing, give notice that he will also consider any specified new issue (see § 410.610) whether pertinent to the same or a related matter, and whether arising subsequent to the request for hearing, which may affect the rights of such party to benefits under this part even though the Administration has not made an initial and reconsidered determination with respect to such new issue: *Provided,* That notice of the time and place of the hearing on any new issue shall, unless waived, be given to the parties within the time and manner specified in § 410.636: *And provided further,* That the determination involved is not one within the jurisdiction of a State agency under a Federal-State agreement entered into pursuant to section 413(b) of the Act. Upon the giving of such notice, the Administrative Law Judge shall, except as otherwise provided, proceed to hearing on such new issue in the same manner as he would on an issue on which an initial and reconsidered determination has been made by the Administration and a hearing requested with respect thereto by a party entitled to such hearing.

§ 410.638 Change of time and place for hearing.

The Administrative Law Judge may change the time and place for the hearing, either on his own motion or for good cause shown by a party. The Administrative Law Judge may adjourn or postpone the hearing, or he may reopen the hearing for the receipt of additional evidence at any time prior to the mailing of notice to the party of the decision in the case. Reasonable notice shall be given to the parties of any change in the time or place of hearing or of an adjournment or a reopening of the hearing.

§ 410.639 Subpenas.

When reasonably necessary for the full presentation of a case, an Administrative Law Judge (formerly called ''hearing examiner'') or a member of the Appeals Council, may, either upon his own motion or upon the request of a party, issue subpenas for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents which are relevant and material to any matter in issue at the hearing. Parties who desire the issuance of a subpena shall, not less than 5 days prior to the time fixed for the hearing, file with the Administrative Law Judge or at a district office of the Administration a written request therefor, designating the witnesses or documents to be produced, and describing the address or location thereof with sufficient particularity to permit such witnesses or documents to be found. The request for a subpena shall state the pertinent facts which the party expects to establish by such witnesses or documents and whether such facts could be established by other evidence without the use of a subpena. Subpenas, as provided for above, shall be issued in the name of the Commissioner, and the Administration shall pay the cost of the issuance and the fees and mileage of any witness so subpenaed, as provided in section 205(d) of the Social Security Act.

[37 FR 20652, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§ 410.640 Conduct of hearing.

Hearings shall be open to the parties and to such other persons as the Administrative Law Judge deems necessary and proper. The Administrative Law Judge shall inquire fully into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material to such matters. If the Administrative Law Judge believes that there is relevant and material evidence available which has not been presented at the hearing, the Administrative Law Judge may adjourn the hearing or, at any time prior to the mailing of notice of the decision, reopen the hearing for the receipt of such evidence. The order in which evidence and allegations shall be presented and the procedure at the hearing generally, except as these regulations otherwise expressly provide, shall be in the discretion of the Administrative Law Judge and of such nature as to afford the parties a reasonable opportunity for a fair hearing.

§ 410.641 Evidence.

Evidence may be received at the hearing even though inadmissible under rules of evidence applicable to court procedures.

§ 410.642 Witnesses.

Witnesses at the hearing shall testify under oath or affirmation or as directed by the Administrative Law Judge, unless they are excused by the Administrative Law Judge for cause. The Administrative Law Judge may examine the witnesses and shall allow the parties or their representatives to do so. If the Administrative Law Judge conducts the examination of a witness, he may allow the parties to suggest matters as to which they desire the witness to be questioned, and the Administrative Law Judge shall question the witness with respect to such matters if they are relevant and material to any issue pending for decision before him.

§ 410.643 Oral argument and written allegations.

The parties, upon their request, shall be allowed a reasonable time for the presentation of oral argument or for the filing of briefs or other written statements of allegations as to facts or law. Where there is more than one party to the hearing, copies of any brief or other written statement shall be filed in sufficient number that they may be made available to any party.

§ 410.644 Record of hearing.

A complete record of the proceedings at the hearing shall be made. The record shall be transcribed in any case which is certified to the Appeals Council without decision by the Administrative Law Judge (see §§ 410.654 and 410.657 to 410.659 inclusive), in any case where a civil action is commenced against the Commissioner (see

§ 410.666), or in any other case when directed by the Administrative Law Judge or the Appeals Council.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38453, July 18, 1997]

§ 410.645 Joint hearings.

When two or more hearings are to be held, and the same or substantially similar evidence is relevant and material to the matters in issue at each such hearing, the Administrative Law Judge (formerly called ''hearing examiner'') may fix the same time and place for each hearing and conduct all such hearings jointly. However, where there is no common issue of law or fact involved in two or more hearings and any party objects to a joint hearing, a joint hearing may not be held. Where joint hearings are held, a single record of the proceedings shall be made and the evidence introduced in one case may be considered as introduced in the others, and a separate or joint decision shall be made, as appropriate.

[37 FR 20652, Sept. 30, 1972]

§ 410.646 Consolidated issues.

When one or more additional issues are raised by the Administrative Law Judge pursuant to § 410.637, such issues may, in the discretion of the Administrative Law Judge, be consolidated for hearing and decision with other issues pending before him upon the same request for a hearing, whether or not the same or substantially similar evidence is relevant and material to the matters in issue. A single decision may be made upon all such issues.

§ 410.647 Waiver of right to appear and present evidence.

(a) *General.* Any party to a hearing shall have the right to appear before the Administrative Law Judge (formerly called ''hearing examiner''), personally or by representative, and present evidence and contentions. If all parties are unwilling, unable, or waive their right to appear before the Administrative Law Judge, personally or by representative, it shall not be necessary for the Administrative Law Judge to conduct an oral hearing as provided in §§ 410.636 to 410.646, inclusive. A waiver of the right to appear and present evidence and allegations as to facts and law shall be made in writing and filed with the Administrative Law Judge. Such waiver may be withdrawn by a party at any time prior to the mailing of notice of the decision in the case. Even though all of the parties have filed a waiver of the right to appear and present evidence and contentions at a hearing before the Administrative Law Judge, the Administrative Law Judge may, nevertheless, give notice of a time and place and conduct a hearing as provided in §§ 410.636 to 410.646, inclusive, if he believes that the personal appearance and testimony of the party or parties would assist him to ascertain the facts in issue in the case.

(b) *Record as basis for decision.* Where all of the parties have waived their right to appear in person or through a representative and the Administrative Law Judge does not schedule an oral hearing, the decision shall be based on the record. Where a party residing outside the United States at a place not readily accessible to the United States does not indicate that he wishes to appear in person or through a representative before an Administrative Law Judge, and there are no other parties to the hearing who wish to appear, the Administrative Law Judge may decide the case on the record. In any case where the decision is to be based on the record, the Administrative Law Judge shall make a record of the relevant written evidence, including applications, written statements, certificates, affidavits, reports, and other documents which were considered in connection with the initial determination and reconsideration, and whatever additional relevant and material evidence the party or parties may present in writing for consideration by the Administrative Law Judge. Such documents shall be considered as all of the evidence in the case.

[37 FR 20652, Sept. 30, 1972]

§ 410.648 Dismissal of request for hearing; by application of party.

With the approval of the Administrative Law Judge at any time prior to the mailing of notice of the decision, a

request for a hearing may be withdrawn or dismissed upon the application of the party or parties filing the request for such hearing. A party may request a dismissal by filing a written notice of such request with the Administrative Law Judge or orally stating such request at the hearing.

§ 410.649 Dismissal by abandonment of party.

With the approval of the Administrative Law Judge, a request for hearing may also be dismissed upon its abandonment by the party or parties who filed it. A party shall be deemed to have abandoned a request for hearing if neither the party nor his representative appears at the time and place fixed for the hearing and either (a) prior to the time for hearing such party does not show good cause as to why neither he nor his representative can appear or (b) within 10 days after the mailing of a notice to him by the Administrative Law Judge to show cause, such party does not show good cause for such failure to appear and failure to notify the Administrative Law Judge prior to the time fixed for hearing that he cannot appear.

§ 410.650 Dismissal for cause.

The presiding officer may, on his own motion, dismiss a hearing request, either entirely or as to any stated issue, under any of the following circumstances:

(a) *Res judicata.* Where there has been a previous determination or decision by the Commissioner with respect to the rights of the same party on the same facts pertinent to the same issue or issues which has become final either by judicial affirmance or, without judicial consideration, upon the claimant's failure timely to request reconsideration, hearing, or review, or to commence a civil action with respect to such determination or decision (see §§ 410.624, 410.631, 410.661, and 410.666).

(b) *No right to hearing.* Where the party requesting a hearing is not a proper party under § 410.632 or § 410.633 or does not otherwise have a right to a hearing under § 410.630. This would include, but is not limited to, an individual claiming as a representative payee appointed pursuant to § 410.581 (see § 410.615).

(c) *Hearing request not timely filed.* Where the party has failed to file a hearing request timely pursuant to § 410.631 and the time for filing such request has not been extended as provided in § 410.669.

(d) *Death of party.* Where the party who filed the hearing request dies and there is no information before the presiding officer or the Social Security Administration showing that an individual who is not a party may be prejudiced by the Social Security Administration's determination which is the subject of the request for hearing: *Provided;* That if, within 60 days after the date notice of such dismissal is mailed to the original party at his last known address any such other individual states in writing that he desires a hearing on such claim and shows that he may be prejudiced by the Social Security Administration's initial determination, then the dismissal of the request for hearing shall be vacated.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 20653, Sept. 30, 1972; 41 FR 54753, Dec. 15, 1976; 62 FR 38453, July 18, 1997]

§ 410.651 Notice of dismissal and right to request review thereon.

Notice of the Administrative Law Judge's dismissal action shall be given to the parties or mailed to them at their last known addresses. Such notice shall advise the parties of their right to request review of the dismissal action by the Appeals Council (see § 410.660).

§ 410.652 Effect of dismissal.

The dismissal of a request for hearing shall be final and binding unless vacated (see § 410.653).

§ 410.653 Vacation of dismissal of request for hearing.

A presiding officer or the Appeals Council may, on request of the party and for good cause shown, vacate any dismissal of a request for hearing at any time within 60 days after the date of receipt of the notice of dismissal by the party requesting the hearing at his last known address. For purposes of this section, the date of receipt of the dismissal notice shall be presumed to

be 5 days after the date of such notice, unless there is a reasonable showing to the contrary. In any case where a presiding officer has dismissed the hearing request, the Appeals Council may, on its own motion, within 60 days after the mailing of such notice, review such dismissal and may, in its discretion vacate such dismissal.

[41 FR 54753, Dec. 15, 1976]

§ 410.654 Administrative Law Judge's decision or certification to Appeals Council.

As soon as practicable after the close of a hearing, the Administrative Law Judge, except as herein provided, shall make a decision in the case or certify the case with a recommended decision to the Appeals Council for decision (see §§ 410.657 through 410.659). If the Administrative Law Judge makes a decision in the case, such decision shall be based upon the evidence adduced at the hearing (§§ 410.636 through 410.646, inclusive) or otherwise included in the hearing record (see § 410.647). The decision shall be made in writing and contain findings of fact and a statement of reasons. A copy of the decision shall be mailed to the parties at their last known addresses.

§ 410.655 Effect of Administrative Law Judge's decision.

The decision of the Administrative Law Judge provided for in § 410.654, shall be final and binding upon all parties to the hearing unless it is reviewed by the Appeals Council (see §§ 410.663 through 410.665) or unless it is revised in accordance with § 410.671, or unless the expedited appeals process is used, in accordance with § 410.629a. If a party's request for review of the Administrative Law Judge's decision is denied (see § 410.662) or is dismissed (see § 410.667), such decision shall be final and binding upon all parties to the hearing unless a civil action is filed in a district court of the United States, as is provided in section 205(g) of the Social Security Act, as incorporated in the Federal Coal Mine Health and Safety Act by section 413(b) of that Act (see § 410.670a), or unless the decision is revised in accordance with § 410.671.

[40 FR 53388, Nov. 18, 1975]

§ 410.656 Removal of hearing to Appeals Council.

The Appeals Council on its own motion may remove to itself any request for hearing pending before an Administrative Law Judge. The hearing on any matter so removed to the Appeals Council shall be conducted in accordance with the requirements of §§ 410.637 to 410.653, inclusive. Notice of such removal shall be mailed to the parties at their last known addresses.

§ 410.657 Appeals Council proceedings on certification and review; procedure before Appeals Council on certification by the Administrative Law Judge.

When a case has been certified to the Appeals Council by an Administrative Law Judge with his recommended decision (see § 410.654), the Administrative Law Judge shall mail notice of such action to the parties at their last known addresses. The parties shall be notified of their right to file with the Appeals Council within 10 days from the date of mailing of the recommended decision, briefs or other written statements of exceptions or allegations as to applicable fact and law, except in the case of suspension or disqualification (see § 410.694(b)). Upon request of any party made within such 10-day period, a 10-day extension of time for filing such briefs or statements shall be granted and, upon a showing of good cause, such 10-day period may be extended, as appropriate. Where there is more than one party, copies of such briefs or written statements shall be filed in sufficient number that they may be made available to any party requesting a copy or any other party designated by the Appeals Council. Copies or a statement of the contents of the documents or other written evidence received in evidence in the hearing record, and a copy of the transcript of oral evidence adduced at the hearing, if any, or a condensed statement thereof shall be made available to any party upon request, upon payment of the cost, or if such cost is not readily determinable, the estimated amount thereof, unless, for good cause shown, such payment is waived. When a case has been certified to the Appeals Council by an Administrative Law Judge for decision any

party shall be given, upon his request, a reasonable opportunity to appear before the Appeals Council for the purpose of presenting oral argument.

§ 410.658 Evidence in proceeding before Appeals Council.

Evidence in addition to that admitted into the hearing record by the Administrative Law Judge may not be received as evidence except where it appears to the Appeals Council that such additional evidence may affect its decision. If no additional material is presented, but such evidence is available and may affect its decision, the Appeals Council shall receive such evidence or designate an Administrative Law Judge or member of the Appeals Council before whom the evidence shall be introduced. Before such additional evidence is received, notice that evidence will be received with respect to certain matters shall be mailed to the parties, unless such notice is waived, at their last known addresses, and the parties shall be given a reasonable opportunity to present evidence which is relevant and material to such matters. When the additional evidence is presented to an Administrative Law Judge or a member of the Appeals Council, a transcript or a condensed statement of such evidence shall be made available to any party upon request, upon payment of the cost, or if such cost is not readily determinable, the estimated amount thereof, unless, for good cause shown, such payment is waived.

§ 410.659 Decision of Appeals Council.

The decision of the Appeals Council, when a case has been certified to it by an Administrative Law Judge along with his recommended decision, shall be made in accordance with the provisions of § 410.665.

§ 410.660 Right to request review of Administrative Law Judge's decision or dismissal.

If an Administrative Law Judge has made a decision, as provided in § 410.654, or dismissed a request for hearing, as provided in §§ 410.648 through 410.650, any party thereto may request the Appeals Council to review such decision or dismissal.

§ 410.661 Time and place of filing request.

The request for review shall be made in writing and filed with an office of the Social Security Administration, or with a presiding officer, or the Appeals Council. Such request shall be accompanied by whatever documents or other evidence the party desires the Appeals Council to consider in its review. The request for review must be filed within 60 days after the date of receipt of notice of the presiding officer's decision or dismissal, unless the time is extended as provided in § 410.669. For purposes of this section, the date of receipt of notice of the presiding officer's decision or dismissal shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary.

[41 FR 54753, Dec. 15, 1976]

§ 410.662 Action by Appeals Council on review.

The Appeals Council may dismiss (see § 410.667) or, in its discretion, deny or grant a party's request for review of a presiding officer's decision, or may, on its own motion, within 60 days after the date of the notice of such decision, reopen such decision for review or for the purpose of dismissing the party's request for hearing for any reason for which it could have been dismissed by the presiding officer (see §§ 410.648 through 410.650). Notice of the action by the Appeals Council shall be mailed to the party at his last known address.

[41 FR 54753, Dec. 15, 1976]

§ 410.663 Procedure before Appeals Council on review.

(a) *Availability of documents or other written statements.* Whenever the Appeals Council determines to review a presiding officer's decision (except when the case is remanded to a presiding officer in accordance with § 410.665), the Appeals Council shall make available to any party upon request, copies or a statement of the contents of the documents or other written evidence upon which the presiding officer's decision was based, and a copy of the transcript of oral evidence, if any, or a condensed statement thereof, upon payment of the cost, or if such

cost is not readily determinable, the estimated amount thereof, unless for good cause shown, such payment is waived.

(b) *Filing briefs or other written statements.* The parties shall be given, upon request, a reasonable opportunity to file briefs or other written statements of allegations as to fact and law. Copies of each brief or other written statements, where there is more than one party, shall be filed in sufficient number that they may be made available to any party requesting a copy and to any other party designated by the Appeals Council.

(c) *Appearance to present oral argument.* Any party may request an appearance before the Appeals Council for the purpose of presenting oral argument. Such request shall be granted where the Appeals Council determines that a significant question of law or policy is presented or where the Appeals Council is of the opinion that such oral argument would be beneficial in rendering a proper decision in the case. Where the request for appearance is granted, the party will be notified of the time and place for the appearance at least 10 days prior to the date of the scheduled appearance.

[41 FR 53790, Dec. 9, 1976]

§410.664 Evidence admissible on review.

(a) *Admissibility of additional evidence.* Evidence in addition to that introduced at the hearing before the presiding officer, or documents before the presiding officer where such hearing was waived (see §410.647), may not be admitted except where it appears to the Appeals Council that such evidence is relevant and material to an issue before it and thus may affect its decision.

(b) *Receipt of evidence by Presiding Officer.* Where the Appeals Council determines that additional evidence is needed for a sound decision, it will remand the case to a presiding officer for receipt of the evidence, further proceedings, and a new decision, except where the Appeals Council can obtain the evidence more expeditiously and the rights of the claimant will not be adversely affected.

(c) *Receipt of evidence by Appeals Council.* Where the Appeals Council obtains the evidence itself, before such evidence is admitted into the record, notice that evidence will be received with respect to certain issues shall be mailed to the parties, unless such notice is waived, at their last known addresses, and the parties shall be given a reasonable opportunity to comment thereon and to present evidence which is relevant and material to such issues.

(d) *Copies of evidence.* When additional evidence is presented to a presiding officer or to the Appeals Council, a transcript or a condensed statement of such evidence shall be made available to any party upon request, upon payment of the cost, or if such cost is not readily determinable, the estimated amount thereof, unless, for good cause shown, such payment is waived.

[41 FR 53790, Dec. 9, 1976]

§410.665 Decision by Appeals Council or remanding of case.

(a) *General.* If a case is certified to the Appeals Council by an Administrative Law Judge (see §410.654), the Appeals Council shall make a decision. If the Appeals Council decides to review an Administrative Law Judge's decision as provided in §410.662, the Appeals Council may, upon such review, affirm, modify, or reverse the decision of the Administrative Law Judge, or vacate such decision and remand the case to an Administrative Law Judge either for rehearing and the issuance of a decision thereon or to take further testimony in the case and return it to the Appeals Council with a recommended decision for decision by the Appeals Council. Where a case has been remanded by a court for further consideration, the Appeals Council may proceed then to make the decision or it may in turn remand the case to an Administrative Law Judge with directions to return the case upon completion of the necessary action to the Appeals Council with a recommended decision for decision by the Appeals Council.

(b) *Case remanded to an Administrative Law Judge.* Where a case is remanded to an Administrative Law Judge, he shall initiate such additional proceedings and take such other action (under §§410.632 through 410.655) as is directed

by the Appeals Council in its order of remand. The Administrative Law Judge may take any additional action not inconsistent with the order of remand. Upon completion of all action called for by the order of remand and any other action initiated by the Administrative Law Judge, the Administrative Law Judge shall promptly (1) issue a decision in writing which contains findings of fact and a statement of reasons, or (2) when so directed by the Appeals Council, return the case with his recommended decision to the Appeals Council for its decision. A copy of the decision shall be mailed to each party at his last known address. When a recommended decision is issued, the Administrative Law Judge shall also notify each party of his right to file with the Appeals Council within 10 days from the the date of mailing of the recommended decision, briefs or other written statements of exceptions and allegations as to applicable fact and law, except in the case of suspension or disqualification (see § 410.694(b)). Upon request of any party made within such 10-day period, a 10-day extension of time for filing such briefs or statements shall be granted and, upon a showing of good cause, such 10-day period may be extended, as appropriate.

(c) *Decision by Appeals Council.* A decision of the Appeals Council shall be based upon the evidence received into the hearing record and such further evidence as the Appeals Council may receive as provided in §§ 410.657, 410.658, 410.663, and 410.664. This decision shall be made in writing and contain findings of fact, and a statement of reasons. A copy of the decision shall be mailed to each party at his last known address.

§ 410.666 Effect of Appeals Council's decision or refusal to review.

The Appeals Council may deny a party's request for review or it may grant review and either affirm or reverse the Administrative Law Judge's decision. The decision of the Appeals Council, or the decision of the Administrative Law Judge where the request for review of such decision is denied (see § 410.662), shall be final and binding upon all parties to the hearing unless a civil action is filed in a district court of the United States under the provisions of section 205(g) of the Social Security Act, as incorporated by section 413(b) of the Act (see § 410.670a), or unless the decision is revised under the provisions described in § 410.671.

[37 FR 20653, Sept. 30, 1972]

§ 410.667 Dismissal by Appeals Council.

The Appeals Council may dismiss a request for review or proceedings before it under any of the following circumstances:

(a) *Upon request of party.* Proceedings pending before the Appeals Council may, with the approval of the Appeals Council, be discontinued and dismissed upon written application of the party or parties who filed the request for review to withdraw such request.

(b) *Death of party.* Proceedings before the Appeals Council, whether on request for review or review on the motion of the Appeals Council, may be dismissed upon the death of a party only if the record affirmatively shows that there is no prejudiced individual who wishes to continue the action.

(c) *Request for review not timely filed.* A request for review of a decision by an Administrative Law Judge shall be dismissed where the party has failed to file a request for review within the time specified in § 410.661 and the time for filing such request has not been extended as provided in § 410.669.

§ 410.668 Extension of time to request reconsideration.

If a party to an initial determination desires to file a request for reconsideration after the time for filing such request has passed (see § 410.624), such party may file a petition with the Administration for an extension of time for the filing of such request. Such petition shall be in writing and shall state the reasons why the request for reconsideration was not filed within the required time. For good cause shown, the component of the Administration which has jurisdiction over the proceedings (see § 410.601) may extend the time for filing the request for reconsideration.

§410.669 Extension of time to request hearing or review or begin civil action.

(a) *General.* Any party to a reconsidered determination, a decision of an Administrative Law Judge (formerly called *hearing examiner*), or a decision of the Appeals Council (resulting from an initial determination as described in §410.610), may petition for an extension of time for filing a request for hearing or review or for commencing a civil action in a district court of the United States, although the time for filing such request or commencing such action (see §§410.631 and 410.661 and section 205(g) of the Social Security Act as incorporated by section 413(b) of the Act), has passed. If an extension of the time fixed by §410.631 for requesting a hearing before an Administrative Law Judge is sought, the petition may be filed with an Administrative Law Judge. In any other case, the petition shall be filed with the Appeals Council. The petition shall be in writing and shall state the reasons why the request or action was not filed within the required time. For good cause shown, an Administrative Law Judge or the Appeals Council, as the case may be, may extend the time for filing such request or action.

(b) *Where civil action commenced against wrong defendant.* If a party to a decision of the Appeals Council, or to a decision of the Administrative Law Judge where the request for review of such decision is denied (see §410.662), timely commences a civil action in a district court as provided by section 205(g) of the Social Security Act as incorporated by section 413(b) of the Act, but names as defendant the United States or any agency, officer, or employee thereof instead of the Commissioner either by name or by official title, and causes process to be served in such action as required by the Federal Rules of Civil Procedure, the Administration shall mail notice to such party that he has named the incorrect defendant in such action; and the time within which such party may commence the civil action pursuant to section 205(g) of the Social Security Act against the Commissioner shall be deemed to be extended to and including the 60th day following the date of mailing of such notice.

[37 FR 20653, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§410.670 Review by Appeals Council.

Where an Administrative Law Judge has determined the matter of extending the time for filing such request (whether he has allowed or denied the request for such extension), the Appeals Council on its own motion may review such determination and either affirm or reverse it. In connection with this review, the Appeals Council may consider whatever additional evidence relevant to this request a party may wish to present.

§410.670a Judicial review.

A civil action may be commenced in a district court of the United States with respect to a decision of the Appeals Council, or to a decision of the Administrative Law Judge (formerly called *hearing examiner*) where the request for review of such decision is denied by the Appeals Council, as provided in section 205 (g) and (h) of the Social Security Act, as incorporated by section 413(b) of the Act.

[37 FR 20653, Sept. 30, 1972]

§410.670b Interim provision for the adjudication of certain claims filed prior to May 19, 1972.

(a) *General.* Section 6 of the Black Lung Benefits Act of 1972 added a section 431 to title IV of the Federal Coal Mine Health and Safety Act of 1969 which requires the Commissioner to review, under the terms of the 1972 amendments, all claims for benefits which were filed prior to May 19, 1972 (the date of enactment of the 1972 amendments), and which were either pending before the Administration on that date, or which had been previously disallowed. Therefore, notwithstanding any other provision of this subpart, and in keeping with the objective of providing for effective and expeditious processing of the large backlog of claims that have to be reexamined under the 1972 amendments, all such claims for benefits will be adjudicated under the terms of the amended Act in accordance with this section.

(b) *Cases remanded by the Federal courts.* (1) Those claims described in paragraph (a) of this section which are remanded to the Commissioner by the Federal courts are reviewed in the Bureau of Hearings and Appeals.

(2) A decision will be rendered by an Administrative Law Judge (formerly called *hearing examiner*) in all such claims which can be allowed under the 1972 amendments on the evidence then of record. Such decision shall be considered the Administrative Law Judge's decision referred to in § 410.654, and a party to the decision may request review thereof by the Appeals Council in accordance with §§ 410.660 and 410.661.

(3) A copy of such Administrative Law Judge's decision shall be mailed to such party at his last known address. The date of mailing of such decision will replace the date of any prior notice of an initial determination for purposes of § 410.672.

(4) Those claims described in paragraph (a) of this section which are remanded to the Commissioner by the Federal courts and which cannot be allowed in the Bureau of Hearings and Appeals under the 1972 amendments on the evidence then of record, shall be remanded to the Administration's Bureau of Disability Insurance for a new determination.

(c) *Claims pending in the Bureau of Hearings and Appeals.* (1) Those claims described in paragraph (a) of this section which are pending before an Administrative Law Judge or the Appeals Council and which can be allowed under the 1972 amendments on the evidence then of record will be decided by an Administrative Law Judge or the Appeals Council, and this decision will constitute the decision referred to in § 410.654 or § 410.665(c).

(2) A copy of such Administrative Law Judge's decision shall be mailed to such party at his last known address. The date of mailing of such decision will replace the date of any prior notice of an initial determination for purposes of § 410.672. Such claims pending before an Administrative Law Judge or the Appeals Council which cannot be allowed under the 1972 amendments on the evidence then of record shall be remanded to the Administration's Bureau of Disability Insurance for a new determination.

(d) *Claims pending in, or remanded to the Bureau of Disability Insurance.* (1) Those claims described in paragraph (a) of this section in which no timely request for hearing has been filed, or in which an Administrative Law Judge or the Appeals Council has previously rendered or affirmed a decision of disallowance, or which have been remanded by the Bureau of Hearings and Appeals in accordance with paragraph (b) or (c) of this section, shall be reviewed in the Bureau of Disability Insurance and a new determination made.

(2) Written notice of such determination shall be mailed to the party at his last known address. If such new determination is adverse to the party in whole or in part, the notice shall explain the basis for the determination. It shall also advise the party of his right to request further consideration of the determination by the Bureau of Disability Insurance if he has additional evidence or contentions as to fact or law to submit. The effective date of such notice shall be a date 30 days later than the date of mailing and shall be expressly indicated in such notice.

(3) Before this effective date, the party may request further consideration of the determination by the Bureau of Disability Insurance if he has additional evidence or contentions as to fact or law to submit. If such further consideration is requested timely, the new determination referred to in paragraph (d)(1) of this section shall not go into effect. Rather, his claim will be further considered as requested and a further determination made. Written notice of the latter determination will be mailed to the party at his last known address. If this determination is adverse to the party in whole or in part, the notice shall explain the basis for the determination. The effective date of such notice shall be the date of mailing.

(4) The effective date of the determination referred to in paragraph (d)(2) or (d)(3) of this section shall replace the date of any prior notice of an initial determination for purposes of § 410.672.

(5) A determination made as provided in paragraph (d)(1) or (d)(3) of this section shall be final and binding upon all parties to such determination unless a hearing is requested within 6 months of the effective date of the notice of the determination, except where a previously filed hearing request or request for review by the Appeals Council or by a court is still pending, in which case the claim will be referred to an Administrative Law Judge for a hearing.

(6) Those claims described in paragraph (a) of this section in which no initial determination has been made shall be adjudicated under the 1972 amendments in accordance with the other provisions of this part.

[37 FR 20653, Sept. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§410.670c 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) The Administration will apply a holding in a United States Court of Appeals decision which it determines conflicts with its interpretation of a provision of the Social Security Act or regulations unless the Government seeks further review or the Administration relitigates the issue presented in the decision in accordance with paragraphs (c) and (d) of this section. The Administration 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 the Administration determines that a United States Court of Appeals holding conflicts with the Administration's 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, the Administration will issue a Social Security Acquiescence Ruling that describes the administrative case and the court decision, identifies the issue(s) involved, and explains how the Administration will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations and decisions made on or after that date. If the Administration makes a determination or decision between the date of a circuit court decision and the date an Acquiescence Ruling is published, 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, the Administration 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. A 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 that request is denied, the Administration shall extend the time to file an appeal on the merits of the claim to sixty days after the date that the request for readjudication is denied.

(c) After the Administration has published a Social Security Acquiescence Ruling to reflect a holding of a United States Court of Appeals on an issue, the Administration may decide under certain conditions to relitigate that issue within the same circuit. The Administration 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 the Administration's 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 the Administration bases a Social Security Acquiescence Ruling.

(2) The General Counsel of SSA, after consulting with the Department of Justice, concurs that relitigation of an issue and application of the Administration's interpretation of the Social Security Act or regulations at the administrative level within the circuit would be appropriate.

(3) The Administration publishes a notice in the FEDERAL REGISTER that it intends to relitigate an issue, and that it will apply its interpretation of the Social Security Act or regulations at the administrative level within the circuit. The notice will explain why the Administration made this decision.

(d) When the Administration decides to relitigate an issue, it will provide a notice explaining its action to all affected claimants. In adjudicating claims subject to relitigation, decision-makers throughout the SSA administrative review process will apply the Administration's 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, the Administration will maintain a listing of all claimants who receive this notice and will provide them the relief ordered by the court.

(e) The Administration will rescind as obsolete a Social Security Acquiescence Ruling and apply its interpretation of the Social Security Act or regulations by publishing a notice in the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) The Administration subsequently clarifies, modifies or revokes the regulation or ruling that was the subject of a circuit court holding that the Administration determined conflicts with its interpretation of the Social Security Act or regulations, or it subsequently publishes a new regulation(s) addressing an issue(s) not previously included in its regulations when that issue(s) was the subject of a circuit court holding that conflicted with its interpretation of the Social Security Act or regulations and that holding was not compelled by the statute or Constitution.

[55 FR 1019, Jan. 11, 1990, as amended at 62 FR 38453, July 18, 1997]

§ 410.671 Revision for error or other reason; time limitation generally.

(a) *Initial, revised or reconsidered determination.* Except as otherwise provided in § 410.675, an initial, revised or reconsidered determination (see §§ 410.610 and 410.627) may be revised by the appropriate component of the Administration having jurisdiction over the proceedings (§ 410.601), on its own motion or upon the petition of any party for a reason, and within the time period, prescribed in § 410.672.

(b) *Decision or revised decision of an Administrative Law Judge or the Appeals Council.* Either upon the motion of the Administrative Law Judge or the Appeals Council, as the case may be, or upon the petition of any party to a hearing, except as otherwise provided in § 410.675, any decision of an Administrative Law Judge provided for in § 410.654 or any revised decision may be revised by such Administrative Law

Judge, or by another Administrative Law Judge if the Administrative Law Judge who issued the decision is unavailable, or by the Appeals Council for a reason and within the time period prescribed in § 410.672. Any decision of the Appeals Council provided for in § 410.665 or any revised decision of the Appeals Council, may be revised by the Appeals Council for a reason and within the time period prescribed in § 410.672. For the purpose of this paragraph (b), an Administrative Law Judge shall be considered to be unavailable if among other circumstances, such hearing examiner has died, terminated his employment, is on leave of absence, has had a transfer of official station, or is unable to conduct a hearing because of illness.

§ 410.672 Reopening initial, revised or reconsidered determinations of the Administration and decisions of an Administrative Law Judge or the Appeals Council; finality of determinations and decisions.

An initial, revised or reconsidered determination of the Administration or a decision, or revised decision of an Administrative Law Judge or of the Appeals Council which is otherwise final under § 410.621, § 410.629, § 410.655, or § 410.666 may be reopened:

(a) Within 12 months from the date of the notice of the initial determination (see § 410.620), to the party to such determination, or

(b) After such 12-month period, but within 4 years after the date of the notice of the initial determination (see § 410.620) to the party to such determination, upon a finding of good cause for reopening such determination or decision, or

(c) At any time, when:

(1) Such initial, revised, or reconsidered determination or decision was procured by fraud or similar fault of the claimant or some other person; or

(2) An adverse claim has been filed; or

(3) An individual previously determined to be dead, and on whose account entitlement of a party was established, is later found to be alive; or

(4) The death of the individual on whose account a party's claim was denied for lack of proof of death is established—

(i) By reason of an unexplained absence from his or her residence for a period of 7 years (see § 410.240(g)(2)); or

(ii) By location or identification of his or her body; or

(5) Such initial, revised, or reconsidered determination or decision is unfavorable, in whole or in part, to the party thereto but only for the purpose of correcting clerical error or error on the face of the evidence on which such determination or decision was based.

[36 FR 23760, Dec. 14, 1971, as amended at 49 FR 46370, Nov. 26, 1984]

§ 410.673 Good cause for reopening a determination or decision.

Good cause shall be deemed to exist where:

(a) New and material evidence is furnished after notice to the party to the initial determination;

(b) A clerical error has been made in the computation of benefits;

(c) There is an error as to such determination or decision on the face of the evidence on which such determination or decision is based.

§ 410.674 Finality of suspension of benefit payments for entire taxable year because of earnings.

Notwithstanding the provisions in § 410.672, a suspension of benefit payments for an entire taxable year because of earnings therein, may be reopened only within the time period and subject to the conditions provided in section 203(b)(1)(B) of the Social Security Act.

§ 410.675 Time limitation for revising finding suspending benefit payments for entire taxable year because of earnings.

No determination of the Administration or decision of an Administrative Law Judge or the Appeals Council shall be revised after the expiration of the normal period for requesting reconsideration, hearing or review, with respect to such determination or decision (see §§ 410.624, 410.631, 410.661, and 410.666) to correct a finding which suspends benefit payments for an entire taxable year because of earnings therein, unless the correction of such finding is permitted under section 203(h)(1)(B) of the Social Security Act.

§ 410.675a Late completion of timely investigation.

The Administration may revise a determination or decision after the applicable time period in § 410.672(a) or § 410.672(b) expires if the Administration begins an investigation to determine whether to revise the determination or decision before the applicable time period expires. The Administration may begin the investigation based either on a request by the party or an action by the Administration. 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 the Administration has diligently pursued the investigation to its conclusion, the Administration may revise the determination or decision. The revision may be favorable or unfavorable to the party. *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 the Administration concludes the investigation and if necessary, revises the determination or decision within 6 months from the date the Administration begins the investigation.

(b) If the Administration has not diligently pursued the investigation to its conclusion, the administration will revise the determination or decision if a revision is applicable and if it will be favorable to the party. The Administration will not revise the determination or decision if it will be unfavorable to the party.

[49 FR 46370, Nov. 26, 1984]

§ 410.676 Notice of revision.

(a) When any determination or decision is revised, as provided in § 410.671 or § 410.675, notice of such revision shall be mailed to the parties to such determination or decision at their last known addresses. The notice of revision which is mailed to the parties shall state the basis for the revised decision.

(b) Where a determination of the Administration is revised under paragraph (a) of this section, the notice of revision shall inform the parties of their right to a hearing as provided in § 410.678.

(c)(1) Where an Administrative Law Judge or the Appeals Council proposes to revise a decision under paragraph (a) of this section and the revision would be based on evidence theretofore not included in the record on which the decision proposed to be revised was based, the parties shall be given notice of the proposal of the Administrative Law Judge or the Appeals Council, as the case may be, to revise such decision, and unless hearing is waived, a hearing with respect to such proposed revision shall be granted as provided in this subpart F.

(2) If a revised decision is appropriate, such decision shall be rendered by the Administrative Law Judge or the Appeals Council, as the case may be, on the basis of the entire record, including the additional evidence. If the decision is revised by an Administrative Law Judge, any party thereto may request review by the Appeals Council (§§ 410.660 and 410.661) or the Appeals Council may review the decision on its own motion (§ 410.662).

§ 410.677 Effect of revised determination.

The revision of a determination or decision shall be final and binding upon all parties thereto unless a party authorized to do so (see § 410.676) files a written request for a hearing with respect to a revised determination in accordance with § 410.678 or a revised decision is reviewed by the Appeals Council as provided in this subpart F, or such revised determination or decision is further revised in accordance with § 410.672.

§ 410.678 Time and place of requesting hearing on revised determination.

The request for hearing shall be made in writing and filed at an office of the Social Security Administration, or with a presiding officer, or the Appeals Council, within 60 days after the date of receipt of notice of the revised determination. Upon the filing of such a request, a hearing with respect to such revision shall be held (see §§ 410.631 through 410.653) and a decision made in

accordance with the provisions of § 410.654. For purposes of this section, the date of receipt of notice of the revised determination shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary.

[41 FR 47918, Nov. 1, 1976]

§ 410.679 Finality of findings with respect to other claims for benefits based on the disability or death of a miner.

Findings of fact made in a determination or decision in a claim by one party for benefits may be revised in determining or deciding another claim for benefits based on the disability or death of the same miner, even though such findings may not be revised in the former claim because of the provisions of § 410.672.

§ 410.680 Imposition of reductions.

The imposition of reductions constitutes an initial determination with respect to each month for which a reduction is imposed. A finding that a reduction is not to be imposed is an initial determination for each month with respect to which the circumstances upon which such finding was based remain unchanged. The suspension of benefits, pending a determination as to the applicability of a reduction equivalent to the amount of a deduction because of excess earnings under section 203(b) of the Social Security Act shall not, however, constitute an initial determination (see § 410.615(a)).

§ 410.681 Change of ruling or legal precedent.

Good cause shall be deemed not to exist where the sole basis for reopening the determination or decision is a change of legal interpretation or administrative ruling upon which such determination or decision was made.

§ 410.682 General applicability.

The provisions of §§ 410.672, 410.673, and 410.679 to 410.681, inclusive, shall be applicable notwithstanding any provisions to the contrary in this subpart F.

§ 410.683 Certification of payment; determination or decision providing for payment.

When a determination or decision has been made under any provision of §§ 410.610 to 410.678, inclusive, to the effect that a payment or payments of benefits should be made to any person, the Administration shall, except as hereafter provided, certify to the U.S. Treasury Department the name and address of the person to be paid, the amount of the payment or payments and the time at which such payment or payments should be made.

§ 410.683a [Reserved]

§ 410.683b Transfer or assignment.

The Administration shall not certify any amount for payment to an assignee or transferee of the person entitled to such payment under the Act, nor shall the Administration certify such amount for payment 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 entitled to the payment under the Act.

[37 FR 20654, Sept. 30, 1972]

§ 410.684 Representation of party; appointment of representative.

A party in an action leading to an initial or reconsidered determination, hearing, or review, as provided in §§ 410.610 to 410.678, inclusive, may appoint as his representative in any such proceeding only an individual who is qualified under § 410.685 to act as a representative. Where the individual appointed by a party to represent him is not an attorney, written notice of the appointment must be given, signed by the party appointing the representative, and accepted by the representative appointed. The notice of appointment shall be filed at an office of the Administration, with a hearing examiner, or with the Appeals Council of the Administration, as the case may be. Where the representative appointed is an attorney, in the absence of information to the contrary, his representation

that he has such authority, shall be accepted as evidence of the attorney's authority to represent a party.

§ 410.685 Qualifications of representative.

(a) *Attorney.* Any attorney in good standing who (1) is admitted to practice before a court of a State, territory, district or insular possession or before the Supreme Court of the United States or an inferior Federal court, (2) has not been disqualified or suspended from acting as a representative in proceedings before the Social Security Administration, and (3) is not, pursuant to any provision of law, otherwise prohibited from acting as a representative, may be appointed as a representative in accordance with § 410.684.

(b) *Person other than attorney.* Any person (other than an attorney described in paragraph (a) of this section) who (1) is of good character, in good repute, and has the necessary qualifications to enable him to render valuable assistance to an individual in connection with his claim, (2) has not been disqualified or suspended from acting as a representative in proceedings before the Social Security Administration, and (3) is not, pursuant to any provision of law, otherwise prohibited from acting as a representative, may be appointed as a representative in accordance with § 410.684.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 17707, Aug. 30, 1972]

§ 410.686 Authority of representative.

A representative, appointed and qualified as provided in §§ 410.684 and 410.685, may make or give, on behalf of the party he represents, any request or notice relative to any proceeding before the Administration under part B of title IV of the Act, including reconsideration, hearing and review, except that such representative may not execute a claim for benefits, unless he is a person designated in § 410.222 as authorized to execute a claim. A representative shall be entitled to present or elicit evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to the claim of such party to the same extent as such party. Notice to any party of any administrative action, determination, or decision, or request to any party for the production of evidence may be sent to the representative of such party, and such notice or request shall have the same force and effect as if it had been sent to the party represented. (For fees to representatives for services performed before the Administration for an individual, see § 410.686b.)

[37 FR 20654, Sept. 30, 1972]

§ 410.686a Proceedings before a State or Federal court.

(a) *Representation of claimant in court proceeding.* Any service rendered by any representative in any proceeding before any State or Federal court shall not be considered services in any proceeding before the Social Security Administration for purposes of §§ 410.686 and 410.686b. However, if the representative has also rendered services in connection with the claim in any proceeding before the Administration, as defined in § 410.686e, he must specify what, if any, amount of the fee he desires to charge is for services performed before the Administration, and if he charges any fee for such services, he must file the petition and furnish all of the information required by § 410.686c(a).

(b) *Attorney fee allowed by a Federal court.* In any case where a Federal court in any proceeding under part B of title IV of the Act renders a judgment favorable to a claimant who was represented before the court by an attorney, and the court, pursuant to section 206(b) of the Social Security Act, allows to the attorney as part of its judgment a fee not in excess of 25 percent of the total of past-due benefits to which the claimant is entitled by reason of the judgment, the Administration may certify the amount of such fee for payment to such attorney out of, but not in addition to, the amount of the past-due benefits payable (see § 410.686d(a)). No other fee may be certified for direct payment to such attorney for such representation.

(c) *Past-due benefits defined.* The term *past-due benefits* as used in paragraph (b) of this section means the total accumulated amount of benefits payable under part B of title IV of the Act by reason of the court's judgment through the month prior to the month of the

judgment favorable to the claimant who was represented by the attorney.

[37 FR 17707, Aug. 30, 1972]

§410.686b Fee for services performed for an individual before the Social Security Administration.

(a) *General.* A fee for services performed for an individual before the Social Security Administration in any proceeding under part B of title IV of the Act may be charged and received only as provided in paragraph (b) of this section.

(b) *Charging and receiving fee.* An individual who desires to charge or receive a fee for services rendered for an individual in any proceeding under part B of title IV of the Act before the Administration (see §410.686e), and who is qualified under §410.685, must file a written petition therefor in accordance with §410.686c(a). The amount of the fee he may charge or receive, if any, shall be determined on the basis of the factors described in §410.686c(b) by an authorized official of the appropriate component of the Administration, where the services were concluded by an initial, reconsidered, or revised determination, or by the Bureau of Hearings and Appeals where there is a decision or action by a hearing examiner or the Appeals Council of the Social Security Administration, as the case may be. Every such fee which is charged or received must be approved as provided in this section and no fee shall be charged or received which is in excess of the amount so approved. This rule shall be applicable whether the fee is charged to or received from a party to the proceeding or someone else. Pursuant to section 206(a) of the Social Security Act, in the case of a representative qualified as an attorney under §410.685(a), the Administration may certify the amount of such fee, subject to the limitations in §410.686d(b), for payment out of, but not in addition to, the amount of past-due benefits payable.

(c) *Past-due benefits defined.* The term *past-due benefits* as used in paragraph (b) of this section means the total accumulated amount of benefits payable under part B of title IV of the Act by reason of the favorable determination through the month prior to the month such determination is effectuated.

(d) *Notice of fee determination.* Written notice of a fee determination made in accordance with paragraph (b) of this section shall be mailed to the representative and the claimant at their last known addresses. Such notice shall inform the parties of the amount of the fee authorized, the basis of the determination, the fact that the Administration assumes no responsibility for payment except that pursuant to section 206(a) of the Social Security Act the Administration may certify payment to an attorney, and that each party may request an administrative review of the determination within 30 days of the date of the notice.

(e) *Administrative review of fee determination*—(1) *Request timely filed.* Administrative review of a fee determination will be granted if either the representative or the claimant files a written request for such review at an office of the Social Security Administration within 30 days after the date of the notice of the fee determination. The party requesting the review shall send a copy of the request to the other party. An authorized official of the Social Security Administration who did not participate in the fee determination in question will review the determination. Written notice of the decision made on the administrative review shall be mailed to the representative and the claimant at their last known addresses.

(2) *Request not timely filed.* Where the representative or the claimant files a request for administrative review, in accordance with paragraph (e)(1) of this subsection, but files such request more than 30 days after the date of the notice of the fee determination, the person making the request shall state in writing the reasons why it was not filed within the 30-day period. The Social Security Administration will grant the review only if it determines that there was good cause for not filing the request timely. For purposes of this section, *good cause* is defined as any circumstance or event which would prevent the representative or the claimant from filing the request for review within such 30-day period or

would impede his efforts to do so. Examples of such circumstances include the following:

(i) The representative or claimant was seriously ill or had a physical or mental impairment and such illness prevented him from contacting the Social Security Administration in person or in writing;

(ii) There was a death or serious illness in the individual's family;

(iii) Pertinent records were destroyed by fire or other accidental cause;

(iv) The representative or claimant was furnished incorrect or incomplete information by the Social Security Administration about his right to request review;

(v) The individual failed to receive timely notice of the fee determination;

(vi) The individual transmitted the request to another government agency in good faith within such 30-day period and the request did not reach the Social Security Administration until after such period had expired.

[37 FR 17708, Aug. 30, 1972, as amended at 41 FR 10425, Mar. 11, 1976]

§ 410.686c Petition for approval of fee.

(a) *Filing of petition.* In accordance with § 410.686b, to obtain approval of a fee for services performed before the Social Security Administration in any proceeding under the Act, a representative, upon completion of the proceedings in which he rendered services, must file at an office of the Social Security Administration a written petition which shall contain the following information:

(1) The dates his services began and ended;

(2) An itemization of services rendered by him in a proceeding under the Act, with the amount of time spent in hours, or parts thereof, on each type of service;

(3) The amount of the fee he desires to charge for services performed;

(4) The amount of fee requested or charged for services rendered in the same matter before any State or Federal court;

(5) The amount and itemization of expenses incurred for which reimbursement has been made or is expected;

(6) The special qualifications which enabled him to render valuable services to the claimant (this requirement does not apply where the representative is an attorney); and

(7) A statement showing that a copy of the petition was sent to the person represented.

(b) *Factors considered in evaluating a petition for fee.* In evaluating a request for approval of a fee, the purpose of the coal miner's benefits program—to provide a measure of economic security for the beneficiaries thereof—will be considered, together with the following factors:

(1) The services performed (including type of service);

(2) The complexity of the case;

(3) The level of skill and competence required in rendition of the services;

(4) The amount of time spent on the case;

(5) The results achieved. (While consideration is always to be given to the amount of benefits, if any, which are payable in a case, the amount of fee will not be based on the amount of such benefits alone but on a consideration of all of the factors listed in this section. The benefits payable in a given claim are governed by specific statutory provisions and by the occurrence of termination, deduction, or nonpayment events specified in the law, factors which are unrelated to efforts of the representative. In addition, the amount of accrued benefits payable in a given claim is affected by the length of time that has elapsed since the claimant became entitled to benefits.);

(6) The level of administrative review to which the claim was carried within the Social Security Administration and the level of such review at which the representative entered the proceedings; and

(7) The amount of the fee requested for services rendered, excluding the amount of any expenses incurred, but including any amount previously authorized or requested.

(c) *Time limit for filing petition for approval of attorney fee.* In order for an attorney to receive direct payment of a fee authorized by the Social Security Administration from a claimant's past-due benefits (see § 410.686d(b)), the petition for approval of a fee, or written notice of the intent to file a petition,

should be filed with the Social Security Administration within 60 days of the date the notice of the determination favorable to the claimant is mailed. Where no such petition is filed within 60 days after the date such notice is mailed, written notice shall be sent to the attorney and the claimant, at their last known addresses, that the Social Security Administration will certify for payment to the claimant all the past-due benefits unless the attorney files within 20 days from the date of such notice a written petition for approval of a fee pursuant to paragraphs (a) and (b) of this section, or a written request for an extension of time. The attorney shall send to the claimant a copy of any request for an extension of time. Where the petition is not filed within this time, or by the last day of any extension approved, the Social Security Administration may certify the funds for payment to the claimant. Any fee charged thereafter remains subject to Social Security Administration approval but collection of any such approved fee shall be a matter between the attorney and his client.

[37 FR 17708, Aug. 30, 1972; 37 FR 18525, Sept. 13, 1972, as amended at 41 FR 10425, Mar. 11, 1976]

§410.686d Payment of fees.

(a) *Fees allowed by a Federal court.* Subject to the limitations in §410.686a (b), the Administration shall certify for payment direct to attorneys, out of past-due benefits as defined in §410.686a(c), the amount of fee allowed by a Federal court in a proceeding under part B of title IV of the Act.

(b) *Fees authorized by the Social Security Administration*—(1) *Attorneys.* Except as provided in §410.686c(c), in any case where the Social Security Administration makes a determination favorable to a claimant who was represented by an attorney as defined in §410.685(a) in a proceeding before the Social Security Administration and as a result of such determination past-due benefits, as defined in §410.686b (c), are payable, the Social Security Administration shall certify for payment to the attorney, out of such benefits, whichever of the following is the smallest:

(i) Twenty-five percent of the total of such past-due benefits;

(ii) The amount of attorney's fee set by the Social Security Administration, or

(iii) The amount agreed upon between the attorney and the claimant.

(2) *Persons other than attorneys.* The Administration assumes no responsibility for the payment of any fee which a representative as defined in §410.685(b) (person other than an attorney) has been authorized to charge in accordance with the provisions of §410.686b and will not deduct such fee from benefits payable under the Act to any beneficiary.

(c) *Responsibility of the Social Security Administration.* The Social Security Administration assumes no responsibility for the payment of a fee based on a revised determination where the request for administrative review was not filed timely. (See paragraph (b) of this section for payment of attorney fees authorized by the Social Security Administration.)

[37 FR 17708, Aug. 30, 1972, as amended at 41 FR 10426, Mar. 11, 1976]

§410.686e Services rendered for an individual in a proceeding before the Administration under part B of title IV of the Act.

Services rendered for an individual in a proceeding before the Administration under part B of title IV of the Act consist of services performed for an individual in connection with any claim before SSA under part B of title IV of the Act, including any services in connection with any asserted right calling for an initial or reconsidered determination by the Administration, and a decision or action by a hearing examiner or by the Appeals Council of the Bureau of Hearings and Appeals of the Administration, whether such determination, decision, or action is rendered before or after remand of a claim by a court. Such services include, but are not limited to, services in connection with a claim for benefits; a request for modification of the amount of benefits; the reinstatement of benefits; proof of support; and proof of employment as a coal miner.

[37 FR 17708, Aug. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§ 410.687 Rules governing the representation and advising of claimants and parties.

No attorney or other representative shall:

(a) With intent to defraud, in any matter willfully and knowingly deceive, mislead, or threaten by word, circular, letter, or advertisement, either oral or written, or any claimant or prospective claimant or beneficiary with respect to benefits or any other initial or continued right under the Act; or

(b) Knowingly charge or collect, or make any agreement to charge or collect, directly or indirectly, any fee in connection with any claim except under the circumstances prescribed in § 410.686b, or knowingly charge, demand, receive, or collect for services rendered before a Federal court in connection with a claim under part B of title IV of the Act, any amount in excess of that allowed by a court as described in § 410.686a(b).

(c) Knowingly make or participate in the making or presentation of any false statement, representation, or claim as to any material fact affecting the right of any person to benefits under part B of title IV of the Act, or as to the amount of any benefits; or

(d) Divulge, except as may be authorized by regulations now or hereafter prescribed by the Commissioner, any information furnished or disclosed to him by the Administration relating to the claim or prospective claim of another person (see § 410.120).

[37 FR 17709, Aug. 30, 1972, as amended at 62 FR 38453, July 18, 1997]

§ 410.687a Effective date.

The provisions of §§ 410.686a, 410.686b, 410.686c, 410.686d, and 410.686e, shall be effective upon publication in the FEDERAL REGISTER (8–31–72), with respect to all claims processed thereafter, and shall apply to all legal services rendered in connection with those claims for which a fee has not been fully paid before this effective date, notwithstanding the fact that fee contracts for such services may have been entered into, or services rendered, before this effective date.

[37 FR 17709, Aug. 30, 1972]

§ 410.688 Disqualification or suspension of an individual from acting as a representative in proceedings before SSA.

Whenever it appears that an individual has violated any of the rules in § 410.687, or has been convicted of a violation under section 206 of the Social Security Act, or has otherwise refused to comply with the Commissioner's rules or regulations on representation of claimants, SSA may institute proceedings as herein provided to suspend or disqualify that individual from acting as a representative in proceedings before SSA.

[62 FR 38453, July 18, 1997]

§ 410.689 Notice of charges.

The Deputy Commissioner for Programs and Policy, or his or her designee, will prepare a notice containing a statement of charges that constitutes the basis for the proceeding against the individual. This notice will be delivered to the individual charged, either by certified or registered mail to his last known address or by personal delivery, and will advise the individual charged to file an answer, within 30 days from the date the notice was mailed, or was delivered to him personally, indicating why he should not be suspended or disqualified from acting as a representative before the SSA. This 30-day period may be extended for good cause shown, by the Deputy Commissioner for Programs and Policy, or his or her designee. The answer must be in writing under oath (or affirmation) and filed with the Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235, within the prescribed time limitation. If an individual charged does not file an answer within the time prescribed, he shall not have the right to present evidence. However, see § 410.692(g) relating to statements with respect to sufficiency of the evidence upon which the charges are based or challenging the validity of the proceedings.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 17709, Aug. 30, 1972; 62 FR 38453, July 18, 1997]

§410.690 Withdrawal of charges.

If an answer is filed or evidence is obtained that establishes, to the satisfaction of the Deputy Commissioner for Programs and Policy, or his or her designee, that reasonable doubt exists about whether the individual charged should be suspended or disqualified from acting as a representative before the Administration, the charges may be withdrawn. The notice of withdrawal shall be mailed to the individual charged at his last known address.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38453, July 18, 1997]

§410.691 Referral to the Deputy Commissioner for Programs and Policy, or his or her designee, for hearing and decision.

If action is not taken to withdraw the charges before the expiration of 15 days after the time within which an answer may be filed, the record of the evidence in support of the charges shall be referred to the Deputy Commissioner for Programs and Policy, or his or her designee, with a request for a hearing and a decision on the charges.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38453, July 18, 1997]

§410.692 Hearing on charges.

(a) *Hearing officer.* Upon receipt of the notice of charges, the record, and the request for hearing (see §410.691), the Deputy Commissioner for Programs and Policy, or his or her designee, shall designate an Administrative Law Judge to act as a hearing officer to hold a hearing on the charges. No hearing officer shall conduct a hearing in a case in which he is prejudiced or partial with respect to any party or where he has any interest in the matter pending for decision before him. Notice of any objection which a party to the hearing may have to the hearing officer who has been designated to conduct the hearing shall be made at the earliest opportunity. The hearing officer shall consider the objection(s) and shall, in his discretion, either proceed with the hearing or withdraw. If the hearing officer withdraws, another hearing officer shall be designated as provided in this section to conduct the hearing. If the hearing officer does not withdraw, the objecting party may, after the hearing, present his objections to the Appeals Council as reason why he believes the hearing officer's decision should be revised or a new hearing held before another hearing officer.

(b) *Time and place of hearing.* The hearing officer shall notify the individual charged and the Deputy Commissioner for Programs and Policy, or his or her designee, of the Administration, of the time and place for a hearing on the charges. The notice of the hearing shall be mailed to the individual charged at his last known address and to the Deputy Commissioner for Programs and Policy, or his or her designee, not less than 20 days prior to the date fixed for the hearing.

(c) *Change of time and place for hearing.* The hearing officer may change the time and place for the hearing (see paragraph (b) of this section) either on his own motion or at the request of a party for good cause shown. The hearing officer may adjourn or postpone the hearing, or he may reopen the hearing for the receipt of additional evidence at any time prior to the mailing of notice of the decision in the case (see §410.693). Reasonable notice shall be given to the parties of any change in the time or place of hearing or of any adjournment or reopening of the hearing.

(d) *Parties.* A person against whom charges have been preferred under the provisions of §410.688 shall be a party to the hearing. The Deputy Commissioner for Programs and Policy, or his or her designee, of the Administration, shall also be a party to the hearing.

(e) *Subpenas.* Any party to the hearing may request the hearing officer or a member of the Appeals Council to issue subpenas for the attendance and testimony of witnesses and for the production of books, records, correspondence, papers, or other documents which are relevant and material to any matter in issue at the hearing. The hearing officer may on his own motion issue subpenas for the same purposes when he deems such action reasonably necessary for the full presentation of the facts. Any party who desires the issuance of a subpena shall, not less

than 5 days prior to the time fixed for the hearing, file with the hearing officer a written request therefor, designating the witnesses or documents to be produced, and describing the address or location thereof with sufficient particularity to permit such witnesses or documents to be found. The request for a subpena shall state the pertinent facts which the party expects to establish by such witness or document and whether such facts could be established by other evidence without the use of a subpena. Subpenas, as provided for above, shall be issued in the name of the Commissioner of Social Security, and the Social Security Administration shall pay the cost of the issuance and the fees and mileage of any witness so subpenaed, as provided in section 205(d) of the Social Security Act.

(f) *Conduct of the hearing.* The hearing shall be open to the parties and to such other persons as the hearing officer or the individual charged deems necessary or proper. The hearing officer shall inquire fully into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material to such matters: *Provided, however,* That if the individual charged has filed no answer he shall have no right to present evidence but in the discretion of the hearing officer may appear for the purpose of presenting a statement of his contentions with regard to the sufficiency of the evidence or the validity of the proceedings upon which his suspension or disqualification, if it occurred, would be predicated or, in his discretion, the hearing officer may make or recommend a decision (see § 410.693) on the basis of the record referred in accordance with § 410.691. If the individual has filed an answer and if the hearing officer believes that there is relevant and material evidence available which has not been presented at the hearing, the hearing officer may at any time prior to the mailing of notice of the decision, or submittal of a recommended decision, reopen the hearing for the receipt of such evidence. The order in which the evidence and the allegations shall be presented and the conduct of the hearing shall be at the discretion of the hearing officer.

(g) *Evidence.* Evidence may be received at the hearing, subject to the provision herein, even though inadmissible under the rules of evidence applicable to court procedure. The hearing officer shall rule on the admissibility of evidence.

(h) *Witnesses.* Witnesses at the hearing shall testify under oath or affirmation. The witnesses of a party may be examined by such party or by his representative, subject to interrogation by the other party or by his representative. The hearing officer may ask such questions as he deems necessary. He shall rule upon any objection made by either party as to the propriety of any question.

(i) *Oral and written summation.* The parties shall be given, upon request, a reasonable time for the presentation of an oral summation and for the filing of briefs or other written statements of proposed findings of fact and conclusions of law. Copies of such briefs or other written statements shall be filed in sufficient number that they may be made available to any party in interest requesting a copy and to any other party designated by the Appeals Council.

(j) *Record of hearing.* A complete record of the proceedings at the hearing shall be made and transcribed in all cases.

(k) *Representation.* The individual charged may appear in person and he may be represented by counsel or other representative.

(l) *Failure to appear.* If after due notice of the time and place for the hearing, a party to the hearing fails to appear and fails to show good cause as to why he could not appear, such party shall be considered to have waived his right to be present at the hearing. The hearing officer may hold the hearing so that the party present may offer evidence to sustain or rebut the charges.

(m) *Dismissal of charges.* The hearing officer may dismiss the charges in the event of the death of the individual charged.

(n) *Cost of transcript.* On the request of a party, a transcript of the hearing before the hearing officer will be prepared and sent to the requesting party upon the payment of cost, or if the cost

is not readily determinable, the estimated amount, thereof, unless for good cause such payment is waived.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 17709, Aug. 30, 1972; 62 FR 38454, July 18, 1997]

§410.693 Decision by hearing officer.

(a) *General.* As soon as practicable after the close of the hearing, the hearing officer shall issue a decision (or certify the case with a recommended decision to the Appeals Council for decision under the rules and procedures described in §§410.657 through 410.659) which shall be in writing and contain findings of fact and conclusions of law. The decision shall be based upon the evidence of record. If the hearing officer finds that the charges have been sustained, he shall either:

(1) Suspend the individual for a specified period of not less than 1 year, nor more than 5 years, from the date of the decision, or

(2) Disqualify the individual from further practice before the Administration until such time as the individual may be reinstated under §410.699.

A copy of the decision shall be mailed to the individual charged at his last known address and to the Deputy Commissioner for Programs and Policy, or his or her designee, together with notice of the right of either party to request the Appeals Council to review the decision of the hearing officer.

(b) *Effect of hearing officer's decision.* The hearing officer's decision shall be final and binding unless reversed or modified by the Appeals Council upon review (see §410.697).

(1) If the final decision is that the individual is disqualified from practice before the Administration, he shall not be permitted to represent an individual in a proceeding before the Administration until authorized to do so under the provisions of §410.699.

(2) If the final decision suspends the individual for a specified period of time, he shall not be permitted to represent an individual in a proceeding before the Administration during the period of suspension unless authorized to do so under the provisions of §410.699.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38454, July 18, 1997]

§410.694 Right to request review of the hearing officer's decision.

(a) *General.* After the hearing officer has issued a decision, either of the parties (see §410.692) may request the Appeals Council to review the decision.

(b) *Time and place of filing request for review.* The request for review shall be made in writing and filed with the Appeals Council within 30 days from the date of mailing the notice of the hearing officer's decision, except where the time is extended for good cause. The requesting party shall certify that a copy of the request for review and of any documents that are submitted therewith (see §410.695) have been mailed to the opposing party.

§410.695 Procedure before Appeals Council on review of hearing officer's decision.

The parties shall be given, upon request, a reasonable time to file briefs or other written statements as to fact and law and to appear before the Appeals Council for the purpose of presenting oral argument. Any brief or other written statement of contentions shall be filed with the Appeals Council, and the presenting party shall certify that a copy has been mailed to the opposing party.

§410.696 Evidence admissible on review.

(a) *General.* Evidence in addition to that introduced at the hearing before the hearing officer may not be admitted except where it appears to the Appeals Council that the evidence is relevant and material to an issue before it, and subject to the provisions in this section.

(b) *Individual charged filed answer.* Where it appears to the Appeals Council that additional relevant material is available and the individual charged filed an answer to the charges (see §410.689), the Appeals Council shall require the production of such evidence and may designate a hearing officer or member of the Appeals Council to receive such evidence. Before additional evidence is admitted into the record, notice that evidence will be received with respect to certain issues shall be mailed to the parties, and each party shall be given a reasonable opportunity

to comment on such evidence and to present other evidence which is relevant and material to the issues unless such notice is waived.

(c) *Individual charged did not file answer.* Where the individual charged filed no answer to the charges (see § 410.689), evidence in addition to that introduced at the hearing before the hearing officer may not be admitted by the Appeals Council.

§ 410.697 Decision by Appeals Council on review of hearing officer's decision.

The decision of the Appeals Council shall be based upon evidence received into the hearing record (see § 410.692(j)) and such further evidence as the Appeals Council may receive (see § 410.696) and shall either affirm, reverse, or modify the hearing officer's decision. The Appeals Council, in modifying a hearing officer's decision suspending the individual for a specified period shall in no event reduce a period of suspension to less than 1 year, or in modifying a hearing officer's decision to disqualify an individual shall in no event impose a period of suspension of less than 1 year. Where the Appeals Council affirms or modifies a hearing officer's decision, the period of suspension or disqualification shall be effective from the date of the Appeals Council's decision. Where a period of suspension or disqualification is initially imposed by the Appeals Council, such suspension or disqualification shall be effective from the date of the Appeals Council's decision. The decision of the Appeals Council will be in writing and a copy of the decision will be mailed to the individual at his last known address and to the Deputy Commissioner for Programs and Policy, or his or her designee.

[36 FR 23760, Dec. 14, 1971, as amended at 37 FR 17709, Aug. 30, 1972; 62 FR 38454, July 18, 1997]

§ 410.698 Dismissal by Appeals Council.

The Appeals Council may dismiss a request for the review of any proceedings instituted under § 410.688 pending before it in any of the following circumstances:

(a) *Upon request of party.* Proceedings pending before the Appeals Council may be discontinued and dismissed upon written application of the party or parties who filed the request for review provided there is no party who objects to discontinuance and dismissal.

(b) *Death of party.* Proceedings before the Appeals Council may be dismissed upon death of a party against whom charges have been preferred.

(c) *Request for review not timely filed.* A request for review of a hearing officer's decision shall be dismissed when the party has failed to file a request for review within the time specified in § 410.694 and such time is not extended for good cause.

§ 410.699 Reinstatement after suspension or disqualification.

(a) *General.* An individual shall be automatically reinstated to serve as representative before the Administration at the expiration of any period of suspension. In addition, after 1 year from the effective date of any suspension or disqualification, an individual who has been suspended or disqualified from acting as a representative in proceedings before the Administration may petition the Appeals Council for reinstatement prior to the expiration of a period of suspension or following a disqualification order. The petition for reinstatement shall be accompanied by any evidence the individual wishes to submit. The Appeals Council shall notify the Deputy Commissioner for Programs and Policy, or his or her designee, of the receipt of the petition and grant him 30 days in which to present a written report of any experiences which the Administration may have had with the suspended or disqualified individual during the period subsequent to the suspension or disqualification. A copy of any such report shall be made available to the suspended or disqualified individual.

(b) *Basis of action.* A request for revocation of a suspension or a disqualification shall not be granted unless the Appeals Council is reasonably satisfied that the petitioner is not likely in the future to conduct himself contrary to the provisions of the rules and regulations of the Administration.

(c) *Notice.* Notice of the decision on the request for reinstatement shall be mailed to the petitioner and a copy shall be mailed to the Deputy Commissioner for Programs and Policy, or his or her designee.

(d) *Effect of denial.* If a petition for reinstatement is denied, a subsequent petition for reinstatement shall not be considered prior to the expiration of 1 year from the date of notice of the previous denial.

[36 FR 23760, Dec. 14, 1971, as amended at 62 FR 38454, July 18, 1997]

§ 410.699a Penalties for fraud.

The penalty for any person found guilty of willfully making any false or misleading statement or representation for the purpose of obtaining any benefit or statement or payment under this part shall be:

(a) A fine of up to $1,000, or

(b) Imprisonment for not more than 1 year, or

(c) Both (a) and (b).

(Sec. 411, Federal Coal Mine Health and Safety Act of 1969, as amended; 85 Stat. 793, 30 U.S.C. 921)

[43 FR 34781, Aug. 7, 1978]

Subpart G—Rules for the Review of Denied and Pending Claims Under the Black Lung Benefits Reform Act (BLBRA) of 1977

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), sec. 411, 82 Stat. 793 and 30 U.S.C. 902.

SOURCE: 43 FR 34781, Aug. 7, 1978, unless otherwise noted.

§ 410.700 Background.

(a) The Black Lung Benefits Reform Act of 1977 broadens the definitions of *miner* and *pneumoconiosis* and modifies the evidentiary requirements necessary to establish entitlement to black lung benefits. Section 435 of the Black Lung Benefits Reform Act of 1977 requires that each claimant whose claim has been denied or is pending be given the opportunity to have the claim reviewed under this Act. The purpose of the subpart G is to explain the changes and the procedures, and rules which are applicable with regard to the Social Security Administration's review of part B claims in light of the BLBRA of 1977.

(b) Two Government agencies are responsible for the review of claims. The Social Security Administration, upon the request of the claimant, is responsible for the review of claims filed with the Social Security Administration under part B of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, except those claims filed under section 415 of the Act. The Department of Labor, Office of Workers' Compensation Programs is responsible for the review of the following claims:

(1) Claims filed under part C of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended;

(2) Part B claims filed under section 415 of the Act; and

(3) Those part B claims for which the claimant elects review by DOL. The Department of Labor regulations explaining the review procedures for these claims are published at 20 CFR part 727.

[43 FR 34781, Aug. 7, 1978, as amended at 62 FR 38454, July 18, 1997]

§ 410.701 Jurisdiction for determining entitlement under part B.

In order for the Social Security Administration to approve a claim under this subpart G, the evidence on file must show, in a living miner's claim, that the miner was totally disabled due to pneumoconiosis prior to July 1, 1973. In a survivor's claim, the evidence must show (1) that the deceased miner was either totally disabled due to pneumoconiosis at the time of death, or that death was due to pneumoconiosis, and that death occurred prior to January 1, 1974, or (2) that the miner was entitled to part B benefits at the time of death, and that the survivor filed for benefits either within 6 months of such death or before January 1, 1974, whichever is later, regardless of when such death occurred.

§ 410.702 Definitions and terms.

The following definitions shall apply with regard to review under this subpart G.

(a) *Denied Claim* defined. Denied claim means: (1) Any claim that was

filed with the Social Security Administration under part B of title IV of the Act; and

(2) Entitlement to benefits was not established; and

(3) The time limit for any further appeal has expired.

(b) *Pending Claim* defined. Pending claim means: (1) Any claim that was filed with the Social Security Administration under part B of title IV of the Act; and

(2) Entitlement to benefits has not been established; and

(3) The time limit for any appeal has not expired or action is still pending on an appeal which was requested timely, or on which an extension of time to request appeal has been granted.

(c) *Withdrawn Claim* defined. Withdrawn claim means: Any claim that was filed with the Social Security Administration under part B of title IV of the Act which has been previously withdrawn at the request of the claimant. This claim shall not be considered a pending or denied claim.

(d) *Pneumoconiosis* defined. In addition to the definition of pneumoconiosis contained in §§ 410.110(o) and 410.401(b), pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.

(e) *Evidence on file* defined. Evidence on file is information in the black lung claims file, in the social security title II and title XVI disability claims files, or in a person's earnings record, as of March 1, 1978.

(f) *Determining total disability—the working miner.* A miner shall be considered totally disabled when pneumoconiosis prevents the miner from engaging in gainful employment requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity and over a substantial period of time.

(1) In the case of a living miner if there are changed circumstances of employment indicative of reduced ability to perform the miner's usual coal mine work, such miner's employment in a mine shall not be used as conclusive evidence that the miner is not totally disabled.

(2) A deceased miner's employment in a mine at the time of death shall not be used as conclusive evidence that the miner was not totally disabled.

(3) Any miner not totally disabled by complicated pneumoconiosis who has been determined to be eligible for benefits as a result of a claim filed while the miner is engaged in coal mine employment shall be entitled to such benefits if his or her employment terminates within one year after the date the determination becomes final.

(g) *Survivor entitlement for deceased miner—25 years or more coal mine employment.* If a miner died on or before March 1, 1978, and had worked for 25 years or more in one or more coal mines before June 30, 1971, the eligible survivors of the miner shall be enititled to the payment of benefits at the same rate as that under section 412(a)(2) of the Act, unless it is established that at the time of the miner's death the miner was not partially or totally disabled due to pneumoconiosis.

(h) *Miner* defined. A miner is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. A coal mine construction or transportation worker shall be considered a miner to the extent such individual is or was exposed to coal dust as a result of his or her employment in or around a coal mine or preparation facility. In the case of an individual employed in coal transportation or coal mine construction, there shall be a rebuttable presumption that such individual was exposed to coal dust during all periods of such employment occurring in or around a coal mine or coal preparation facility for purposes of determining whether such individual is or was a miner. The presumption may be rebutted by evidence which demonstrates that the individual was not regularly exposed to coal dust during his or her employment in or around a coal mine or preparation facility or that the individual was not regularly employed in or around a coal mine or coal preparation facility. An individual

employed by a coal mine operator, regardless of the nature of such individual's employment, shall be considered a miner unless such individual was not employed in or around a coal mine or coal preparation facility. A person who is or was a self employed miner, independent contractor, or coal mine worker, as described in this paragraph, shall be considered a miner for the purposes of this subpart.

(i) *X-ray rereading prohibition.* Where there is other evidence, such as the kind in §410.414(c), that a miner has a pulmonary or respiratory impairment, a board certified or board eligible radiologist's interpretation of a chest X-ray taken by a radiologist or qualified technician will be accepted if: (1) It is of a quality sufficient to demonstrate the presence of pneumoconiosis and; (2) it was submitted in support of a claim, unless it is established that the claim has been fraudulently represented.

(j) *Acceptance of autopsy reports.* Unless there is reason to believe that an autopsy report is not accurate, or that the condition of the miner is being fraudulently misrepresented, an autopsy report concerning the presence of pneumoconiosis and the stage of advancement of the disease will be accepted if it is already on file.

(k) *Acceptance of affidavits-miner deceased.* Where there is no medical evidence or other relevant evidence (see §410.414(c)) to establish total disability or death due to pneumoconiosis of a deceased miner, affidavits from the spouse and other individuals having knowledge of the deceased miner's physical condition will be sufficient to establish total disability or death due to pneumoconiosis if they are already on file.

[43 FR 34781, Aug. 7, 1978, as amended at 44 FR 10058, Feb. 16, 1979]

§410.703 Adjudicatory rules for determining entitlement to benefits.

(a) *General.* Section 402(f)(2) of the Act provides that the criteria and standards to be applied to a claim reviewed under section 435 of the Act, for determining whether a miner is or was totally disabled due to pneumoconiosis or died due to pneumoconiosis, shall be no more restrictive than the criteria applicable to a claim filed with the Social Security Administration on or before June 30, 1973, under part B of title IV of the Act. In keeping with this provision, the interim evidentiary rules and disability criteria contained in §410.490 will be applicable for this review.

(b) *Payment provisions.* The DOL has sole responsibility for assigning liability for payment purposes. The DOL regulations relating to the amount of benefits payable, the manner of payment and all other provisions published at 20 CFR part 725 shall be applicable to a claim approved under this subpart.

(c) *Date from which benefits are payable.* Benefits for claims reviewed under this subpart G for which entitlement to benefits is established under the BLBRA of 1977 are payable on a retroactive basis for a period which begins no earlier than January 1, 1974.

§410.704 Review procedures.

(a) *Notification.* Each claimant who has filed a claim for benefits under part B of title IV of the Act, and whose claim is either pending before the Social Security Administration or the courts or has been denied on or before March 1, 1978, will be mailed a notice advising that, upon the request of the claimant, the claim shall be:

(1) Reviewed by the Social Security Administration or DOL, Office of Workers' Compensation Programs to see whether entitlement to benefits may be established under the BLBRA of 1977; and

(2) If review by the Social Security Administration is requested, the review will be made on the basis of the evidence on file as of March 1, 1978; and

(3) If review by the Office of Workers' Compensation Programs is requested, the Office of Workers' Compensation Programs will provide an opportunity for additional evidence to be submitted for consideration prior to a determination.

(b) Where the claimant is mentally incompetent or physically incapable, or is a minor, review of the claim may be elected by those people described in §410.222. Where the original claimant is deceased, any person who may be entitled to benefits as a survivor of the claimant, including those described in

§ 410.570(c), may elect review of the claim.

(c) *Effect of review of a pending part B claim under the BLBRA of 1977 on the pending claim.* Part B claims pending before the Social Security Administration or the courts will continue to be processed under the old law at the same time that these claims are being reviewed by the Social Security Administration, at the claimant's request, under the BLBRA of 1977. Claimants would then have two separate and independent claims for benefits pending. Where claims for benefits are reviewed, upon request, under this subpart G and it is determined that entitlement to benefits is established under the BLBRA of 1977, part C benefits may be paid back to January 1, 1974. Where pending part B claims continue to be processed under the old law and it is determined that the claimant is entitled to benefits under the old law, then the benefits may include payment for periods prior to January 1, 1974. Part C benefits payable to an individual for periods beginning with January 1, 1974, are offset by part B benefits payable for the same periods to the individual. Election by claimants to have their pending claims reviewed under the BLBRA of 1977 for payment of benefits back to January 1, 1974, will not affect the processing of their pending part B claims under the old law for payment of benefits prior to January 1, 1974.

(d) *Response to notification.* A request for review by the Social Security Administration or the Office of Workers' Compensation Programs, must be received by the Social Security Administration within 6 months from the date on which the notice is mailed. Upon receipt, the request will be dated and made a part of the claims file. If a request for review by the Social Security Administration or the Office of Workers' Compensation Program is not received by the Social Security Administration within 6 months from the date the notice is mailed, the claimant shall be considered to have waived the right of review afforded by this subpart G unless *good cause* can be established for not responding within this time period. *Good cause* may be established in the following situations:

(1) Circumstances beyond the individual's control, such as extended illness, mental or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished the individual by the Social Security Administration; or

(3) Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to respond within this time period.

Good cause for failure to respond timely does not exist when there is evidence of record that the individual was informed that he or she should respond timely and the individual failed to do so because of negligence or intent not to respond.

(e) *Changing election.* After a claimant has elected review by the Social Security Administration, he or she may change the election any time prior to the date an initial determination is made. If a claimant has elected review by the Office of Workers' Compensation Programs. The claimant may change the election if the Social Security Administration has not yet forwarded the file to the Office of Workers' Compensation Programs. Once the file is forwarded to the Office of Workers' Compensation Programs, a claimant's right to change the election from the Office of Workers' Compensation Programs to the Social Security Administration is governed by the regulations of DOL.

(f) *Social Security Administration review elected.* (1) If review by the Social Security Administration is requested, a complete review of the evidence on file will be made to see if the file establishes entitlement to benefits under the BLBRA of 1977. Evidence on file is information in the black lung claims file, in the social security title II and title XVI disability claims files, or in a person's earnings record, as of March 1, 1978. In the case of a pending claim which is being appealed, this review will not be delayed because of the pending claim. If it is determined that eligibility to benefits can be established, the claims file, including all evidence and other pertinent material in the claims file, will be transferred to the

Office of Worker's Compensation Programs for processing and assignment of liability in accordance with regulations published by DOL at 20 CFR part 727. The decision of the Social Security Administration approving the claim will be binding upon the Office of Worker's Compensation Programs as an initial determination of the claim. The Social Security Administration will notify the claimant of its approval. If the claimant disagrees with any part of the Social Security Administration's determination of approval, the claimant may request review of this determination by the Office of Worker's Compensation Programs. The Social Security Administration has no authority under the BLBRA of 1977 to process an appeal of any determination made by it in reviewing these denied and pending part B claims.

(2) If it is determined that the evidence on file is insufficient to support an award of benefits, the claims file, including all evidence and other pertinent material in the claims file, will be transferred to the Office of Worker's Compensation Programs for further review in accordance with regulations published at 20 CFR part 727. The Social Security Administration will notify the claimant of this action.

(g) *DOL, Office of Workers' Compensation Programs review elected.* If review by the Office of Workers' Compensation Programs is requested, the claims file and all pertinent material will be forwarded to the Office of Workers' Compensation Programs, without review by the Social Security Administration, for processing by the Office of Workers' Compensation Programs in accordance with regulations published at 20 CFR part 727.

[43 FR 34781, Aug. 7, 1978, as amended at 44 FR 10058, Feb. 16, 1979; 44 FR 12164, Mar. 6, 1979; 62 FR 38454, July 18, 1997]

§410.705 Duplicate claims.

(a) *Approved by the Social Security Administration—denied or pending with the Office of Workers' Compensation Programs.* A person whose part B claim for benefits was approved by the Social Security Administration and who also filed a part C claim with the Office of Workers' Compensation Programs which is pending or has been denied shall be entitled to a review of the part C claim by the Office of Workers' Compensation Programs under the BLBRA of 1977.

(b) *Denied or pending with the Social Security Administration—approved by the Office of Workers' Compensation Programs.* A person who has filed a part B 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

Subpart A—Introduction, General Provisions and Definitions

Sec.
416.101 Introduction.
416.105 Administration.
416.110 Purpose of program.
416.120 General definitions and use of terms.
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.

Subpart B—Eligibility

GENERAL

416.200 Introduction.
416.201 General definitions and terms used in this subpart.
416.202 Who may get SSI benefits.
416.203 Initial determinations of SSI eligibility.
416.204 Redeterminations of SSI eligibility.

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

416.210 You do not apply for other benefits.
416.211 You are a resident of a public institution.
416.212 Continuation of full benefits in certain cases of medical confinement.
416.213 You do not accept vocational rehabilitation services.
416.214 You are disabled and drug addiction or alcoholism is a contributing factor material to the determination of disability.
416.215 You leave the United States.
416.216 You are a child of armed forces personnel living overseas.

ELIGIBILITY FOR INCREASED BENEFITS BECAUSE OF ESSENTIAL PERSONS

416.220 General.
416.221 Who is a qualified individual.
416.222 Who is an essential person.
416.223 What happens if you are a qualified individual.
416.250 Experimental, pilot, and demonstration projects in the SSI program.

SPECIAL PROVISIONS FOR PEOPLE WHO WORK DESPITE A DISABLING IMPAIRMENT

416.260 General.
416.261 What are special SSI cash benefits and when are they payable.
416.262 Eligibility requirements for special SSI cash benefits.
416.263 No additional application needed.
416.264 When does the special SSI eligibility status apply.
416.265 Requirements for the special SSI eligibility status.
416.266 Continuation of SSI status for Medicaid.
416.267 General.
416.268 What is done to determine if you must have Medicaid in order to work.
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.

Subpart C—Filing of Applications

GENERAL PROVISIONS

416.301 Introduction.
416.302 Definitions.
416.305 You must file an application to receive supplemental security income benefits.

APPLICATIONS

416.310 What makes an application a claim for benefits.
416.315 Who may sign an application.
416.320 Evidence of authority to sign an application for another.
416.325 When an application is considered filed.

EFFECTIVE FILING PERIOD OF APPLICATION

416.330 Filing before the first month you meet the requirements for eligibility.
416.335 Filing in or after the month you meet the requirements for eligibility.

FILING DATE BASED UPON A WRITTEN STATEMENT OR ORAL INQUIRY

416.340 Use of date of written statement as application filing date.
416.345 Use of date of oral inquiry as application filing date.
416.350 Treating a title II application as an oral inquiry about SSI benefits.

DEEMED FILING DATE BASED ON MISINFORMATION

416.351 Deemed filing date in a case of misinformation.

WITHDRAWAL OF APPLICATION

416.355 Withdrawal of an application.
416.360 Cancellation of a request to withdraw.

Subpart D—Amount of Benefits

416.401 Scope of subpart.
416.405 Cost-of-living adjustments in benefits.
416.410 Amount of benefits; eligible individual.
416.412 Amount of benefits; eligible couple.
416.413 Amount of benefits; qualified individual.
416.414 Amount of benefits; eligible individual or eligible couple in a medical care facility.
416.415 Amount of benefits; eligible individual is disabled child under age 18.
416.420 Determination of benefits; general.
416.421 Determination of benefits; computation of prorated benefits.
416.426 Change in status involving an individual; ineligibility occurs.
416.428 Eligible individual without an eligible spouse has an essential person in his home.
416.430 Eligible individual with eligible spouse; essential person(s) present.
416.432 Change in status involving a couple; eligibility continues.
416.435 Change in status involving a couple; ineligibility occurs.

Subpart E—Payment of Benefits, Overpayments, and Underpayments

416.501 Payment of benefits: General.
416.502 Manner of payment.
416.503 Minimum monthly benefit amount.
416.520 Emergency advance payments.
416.525 Reimbursement to States for interim assistance payments.
416.532 Method of payment when the essential person resides with more than one eligible person.
416.533 Transfer or assignment of benefits.
416.535 Underpayments and overpayments.
416.536 Underpayments—defined.
416.537 Overpayments—defined.
416.538 Amount of underpayment or overpayment.
416.542 Underpayments—to whom underpaid amount is payable.
416.543 Underpayments—applied to reduce overpayments.
416.544 Paying benefits in installments: Drug addiction or alcoholism.
416.545 Paying large past-due benefits in installments.
416.546 Payment into dedicated accounts of past-due benefits for eligible individuals under age 18 who have a representative payee.
416.550 Waiver of adjustment or recovery—when applicable.
416.551 Waiver of adjustment or recovery—effect of.
416.552 Waiver of adjustment or recovery—without fault.
416.553 Waiver of adjustment or recovery—defeat the purpose of the supplemental security income program.
416.554 Waiver of adjustment or recovery—against equity and good conscience.
416.555 Waiver of adjustment or recovery—impede administration.
416.556 Waiver of adjustment or recovery—countable resources in excess of the limits prescribed in §416.1205 by $50 or less.
416.558 Notice relating to overpayments and underpayments.
416.560 Recovery—refund.
416.570 Adjustment—general rule.
416.571 10-percent limitation of recoupment rate—overpayment.
416.580 Referral of overpayments to the Department of the Treasury for tax refund offset—General.
416.581 Notice to overpaid individual.
416.582 Review within SSA that an overpayment is past due and legally enforceable.
416.583 Findings by SSA.

416.584 Review of our records related to the overpayment.
416.585 Suspension of offset.
416.586 Tax refund insufficient to cover amount of overpayment.

Subpart F—Representative Payment

416.601 Introduction.
416.610 When payment will be made to a representative payee.
416.615 Information considered in determining whether to make representative payment.
416.620 Information considered in selecting a representative payee.
416.621 Order of preference in selecting a representative payee.
416.625 Information to be submitted by a representative payee.
416.630 Advance notice of the determination to make representative payment.
416.635 Responsibilities of a representative payee.
416.640 Use of benefit payments.
416.640a Compensation for qualified organizations serving as representative payees.
416.641 Liability for misuse of benefit payments.
416.645 Conservation and investment of benefit payments.
416.650 When a new representative payee will be selected.
416.655 When representative payment will be stopped.
416.660 Transfer of accumulated benefit payments.
416.665 Accounting for benefit payments.

Subpart G—Reports Required

INTRODUCTION

416.701 Scope of subpart.
416.702 Definitions.

REPORT PROVISIONS

416.704 Who must make reports.
416.708 What you must report.
416.710 What reports must include.
416.712 Form of the report.
416.714 When reports are due.

PENALTY DEDUCTIONS

416.722 Circumstances under which we make a penalty deduction.
416.724 Amounts of penalty deductions.
416.726 Penalty period: First failure to report.
416.728 Penalty period: Second failure to report.
416.730 Penalty period: Three or more failures to report.
416.732 No penalty deduction if you have good cause for failure to report timely.

Subpart H—Determination of Age

416.801 Evidence as to age—when required.
416.802 Type of evidence to be submitted.
416.803 Evaluation of evidence.
416.804 Certified copy in lieu of original.
416.805 When additional evidence may be required.
416.806 Expedited adjudication based on documentary evidence of age.

Subpart I—Determining Disability and Blindness

GENERAL

416.901 Scope of subpart.
416.902 General definitions and terms for this subpart.

DETERMINATIONS

416.903 Who makes disability and blindness determinations.
416.903a Program integrity.
416.904 Determinations by other organizations and agencies.

DEFINITION OF DISABILITY

416.905 Basic definition of disability for adults.
416.906 Basic definition of disability for children.
416.907 Disability under a State plan.
416.908 What is needed to show an impairment.
416.909 How long the impairment must last.
416.910 Meaning of substantial gainful activity.
416.911 Definition of disabling impairment.

EVIDENCE

416.912 Evidence of your impairment.
416.913 Medical evidence of your impairment.
416.914 When we will purchase existing evidence.
416.915 Where and how to submit evidence.
416.916 If you fail to submit medical and other evidence.
416.917 Consultative examination at our expense.
416.918 If you do not appear at a consultative examination.

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

416.919 The consultative examination.
416.919a When we will purchase a consultative examination and how we will use it.
416.919b When we will not purchase a consultative examination.

STANDARDS FOR THE TYPE OF REFERRAL AND FOR REPORT CONTENT

416.919f Type of purchased examinations.
416.919g Who we will select to perform a consultative examination.
416.919h Your treating source.
416.919i Other sources for consultative examinations.
416.919j Objections to the medical source designated to perform the consultative examination.
416.919k Purchase of medical examinations, laboratory tests, and other services.
416.919m Diagnostic tests or procedures.
416.919n Informing the medical source of examination scheduling, report content, and signature requirements.
416.919o When a properly signed consultative examination report has not been received.
416.919p Reviewing reports of consultative examinations.
416.919q Conflict of interest.

AUTHORIZING AND MONITORING THE REFERRAL PROCESS

416.919s Authorizing and monitoring the consultative examination.

PROCEDURES TO MONITOR THE CONSULTATIVE EXAMINATION

416.919t Consultative examination oversight.

EVALUATION OF DISABILITY

416.920 Evaluation of disability of adults, in general.
416.920a Evaluation of mental impairments.
416.921 What we mean by a not severe impairment(s) in an adult.
416.922 When you have two or more unrelated impairments—initial claims.
416.923 Multiple impairments.
416.924 How we determine disability for children.
416.924a Age as a factor of evaluation in childhood disability.
416.924b Functioning in children.
416.924c Other factors we will consider.

MEDICAL CONSIDERATIONS

416.925 Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter.
416.926 Medical equivalence for adults and children.
416.926a Functional equivalence for children.
416.927 Evaluating opinion evidence.
416.928 Symptoms, signs, and laboratory findings.
416.929 How we evaluate symptoms, including pain.
416.930 Need to follow prescribed treatment.

PRESUMPTIVE DISABILITY AND BLINDNESS

416.931 The meaning of presumptive disability or presumptive blindness.
416.932 When presumptive payments begin and end.
416.933 How we make a finding of presumptive disability or presumptive blindness.
416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.

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.
416.936 Treatment required for individuals whose drug addiction or alcoholism is a contributing factor material to the determination of disability.
416.937 What we mean by appropriate treatment.
416.938 What we mean by approved institutions or facilities.
416.939 How we consider whether treatment is available.
416.940 Evaluating compliance with the treatment requirements.
416.941 Establishment and use of referral and monitoring agencies.

RESIDUAL FUNCTIONAL CAPACITY

416.945 Your residual functional capacity.
416.946 Responsibility for assessing and determining residual functional capacity.

VOCATIONAL CONSIDERATIONS

416.960 When your vocational background will be considered.
416.961 Your ability to do work depends upon your residual functional capacity.
416.962 If you have done only arduous unskilled physical labor.
416.963 Your age as a vocational factor.
416.964 Your education as a vocational factor.
416.965 Your work experience as a vocational factor.
416.966 Work which exists in the national economy.
416.967 Physical exertion requirements.
416.968 Skill requirements.
416.969 Listing of Medical-Vocational Guidelines in appendix 2 of subpart P of part 404 of this chapter.
416.969a Exertional and nonexertional limitations.

SUBSTANTIAL GAINFUL ACTIVITY

416.971 General.
416.972 What we mean by substantial gainful activity.
416.973 General information about work activity.
416.974 Evaluation guides if you are an employee.

416.975 Evaluation guides if you are self-employed.
416.976 Impairment-related work expenses.

BLINDNESS

416.981 Meaning of blindness as defined in the law.
416.982 Blindness under a State plan.
416.983 How we evaluate statutory blindness.
416.984 If you are statutorily blind and still working.
416.985 How we evaluate other visual impairments.
416.986 Why and when we will find that you are no longer entitled to benefits based on statutory blindness.

DISABILITY REDETERMINATIONS FOR INDIVIDUALS WHO ATTAIN AGE 18

416.987 Disability redeterminations for individuals who attain age 18.

CONTINUING OR STOPPING DISABILITY OR BLINDNESS

416.988 Your responsibility to tell us of events that may change your disability or blindness status.
416.989 We may conduct a review to find out whether you continue to be disabled.
416.989a We may conduct a review to find out whether you continue to be blind.
416.990 When and how often we will conduct a continuing disability review.
416.991 If your medical recovery was expected and you returned to work.
416.992 The trial work period.
416.992a The reentitlement period.
416.993 Medical evidence in continuing disability review cases.
416.994 How we will determine whether your disability continues or ends.
416.994a How we will determine whether your disability continues or ends, and whether you are and have been receiving treatment that is medically necessary and available, disabled children.
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).
416.996 Continued disability or blindness benefits pending appeal of a medical cessation determination.
416.998 If you become disabled by another impairment(s).

Subpart J—Determinations of Disability

GENERAL PROVISIONS

416.1001 Purpose and scope.
416.1002 Definitions.
416.1003 Basic responsibilities for us and the State.

RESPONSIBILITIES FOR PERFORMING THE DISABILITY DETERMINATION FUNCTION

416.1010 How a State notifies us that it wishes to perform the disability determination function.
416.1011 How we notify a State whether it may perform the disability determination function.
416.1013 Disability determinations the State makes.
416.1014 Responsibilities for obtaining evidence to make disability determinations.
416.1015 Making disability determinations.
416.1016 Medical or psychological consultant.
416.1017 Reasonable efforts to obtain review by a qualified psychiatrist or psychologist.
416.1018 Notifying claimant of the disability determination.

ADMINISTRATIVE RESPONSIBILITIES AND REQUIREMENTS

416.1020 General administrative requirements.
416.1021 Personnel.
416.1022 Training.
416.1023 Facilities.
416.1024 Medical and other purchased services.
416.1025 Records and reports.
416.1026 Fiscal.
416.1027 Audits.
416.1028 Property.
416.1029 Participation in research and demonstration projects.
416.1030 Coordination with other agencies.
416.1031 Confidentiality of information and records.
416.1032 Other Federal laws and regulations.
416.1033 Policies and operating instructions.

PERFORMANCE STANDARDS

416.1040 General.
416.1041 Standards of performance.
416.1042 Processing time standards.
416.1043 Performance accuracy standard.
416.1044 How and when we determine whether the processing time standards are met.
416.1045 How and when we determine whether the performance accuracy standard is met.
416.1050 Action we will take if a State agency does not meet the standards.

PERFORMANCE MONITORING AND SUPPORT

416.1060 How we will monitor.
416.1061 When we will provide performance support.
416.1062 What support we will provide.

SUBSTANTIAL FAILURE

416.1070 General.
416.1071 Good cause for not following the Act, our regulations, or other written guidelines.

416.1075 Finding of substantial failure.

HEARINGS AND APPEALS

416.1080 Notice of right to hearing on proposed finding of substantial failure.
416.1081 Disputes on matters other than substantial failure.
416.1082 Who conducts the hearings.
416.1083 Hearings and appeals process.

ASSUMPTION OF DISABILITY DETERMINATION FUNCTION

416.1090 Assumption when we make a finding of substantial failure.
416.1091 Assumption when State no longer wishes to perform the disability determination function.
416.1092 Protection of State employees.
416.1093 Limitation on State expenditures after notice.
416.1094 Final accounting by the State.

Subpart K—Income

GENERAL

416.1100 Income and SSI eligibility.
416.1101 Definition of terms.
416.1102 What is income.
416.1103 What is not income.
416.1104 Income we count.

EARNED INCOME

416.1110 What is earned income.
416.1111 How we count earned income.
416.1112 Earned income we do not count.

UNEARNED INCOME

416.1120 What is unearned income.
416.1121 Types of unearned income.
416.1123 How we count unearned income.
416.1124 Unearned income we do not count.

IN-KIND SUPPORT AND MAINTENANCE

416.1130 Introduction.
416.1131 The one-third reduction rule.
416.1132 What we mean by ''living in another person's household''.
416.1133 What is a pro rata share of household operating expenses.
416.1140 The presumed value rule.
416.1141 When the presumed value rule applies.
416.1142 If you live in a public assistance household.
416.1143 If you live in a noninstitutional care situation.
416.1144 If you live in a nonprofit retirement home or similar institution.
416.1145 How the presumed value rule applies in a nonmedical for-profit institution.

IN-KIND SUPPORT AND MAINTENANCE IN SPECIAL CIRCUMSTANCES

416.1147 How we value in-kind support and maintenance for a couple.
416.1147a Income rules in change–of–status situations involving in–kind support and maintenance.
416.1148 If you have both in-kind support and maintenance and income that is deemed to you.

TEMPORARY ABSENCE

416.1149 What is a temporary absence from your living arrangement.

DISASTERS

416.1150 How we treat income received because of a major disaster.
416.1151 How we treat the repair or replacement of lost, damaged, or stolen resources.

HOME ENERGY ASSISTANCE

416.1157 Support and maintenance assistance.

DEEMING OF INCOME

416.1160 What is deeming of income.
416.1161 Income of an ineligible spouse, ineligible parent, and essential person for deeming purposes.
416.1161a Income for deeming purposes where Medicaid eligibility is affected.
416.1163 How we deem income to you from your ineligible spouse.
416.1165 How we deem income to you from your ineligible parent(s).
416.1166 How we deem income to you and your eligible child from your ineligible spouse.
416.1166a How we deem income to you from your sponsor if you are an alien.
416.1167 Temporary absences and deeming rules.
416.1168 How we deem income to you from your essential person.
416.1169 When we stop deeming income from an essential person.

ALTERNATIVE INCOME COUNTING RULES FOR CERTAIN BLIND INDIVIDUALS

416.1170 General.
416.1171 When the alternative rules apply.

RULES FOR HELPING BLIND AND DISABLED INDIVIDUALS ACHIEVE SELF-SUPPORT

416.1180 General.
416.1181 What a plan to achieve self-support is.
416.1182 When we begin to count the income excluded under the plan.

APPENDIX TO SUBPART K—LIST OF TYPES OF INCOME EXCLUDED UNDER THE SSI PROGRAM AS PROVIDED BY FEDERAL LAWS OTHER THAN THE SOCIAL SECURITY ACT

Subpart L—Resources and Exclusions

416.1201 Resources; general.
416.1202 Deeming of resources.
416.1203 Deeming of resources of an essential person.
416.1204 Deeming of resources of the sponsor of an alien.
416.1204a Deeming of resources where Medicaid eligibility is affected.
416.1205 Limitation on resources.
416.1207 Resources determinations.
416.1208 How funds held in financial institution accounts are counted.
416.1210 Exclusions from resources; general.
416.1212 Exclusion of the home.
416.1216 Exclusion of household goods and personal effects.
416.1218 Exclusion of the automobile.
416.1220 Property essential to self-support; general.
416.1222 How income-producing property essential to self-support is counted.
416.1224 How nonbusiness property used to produce goods or services essential to self-support is counted.
416.1225 An approved plan for self-support; general.
416.1226 What a plan to achieve self-support is.
416.1227 When the resources excluded under a plan to achieve self-support begin to count.
416.1228 Exclusion of Alaskan natives' stock in regional or village corporations.
416.1229 Exclusion of payments received as compensation for expenses incurred or losses suffered as a result of a crime.
416.1230 Exclusion of life insurance.
416.1231 Burial spaces and certain funds set aside for burial expenses.
416.1232 Replacement of lost, damaged, or stolen excluded resources.
416.1233 Exclusion of certain underpayments from resources.
416.1234 Exclusion of Indian lands.
416.1235 Exclusion of earned income tax credit.
416.1236 Exclusions from resources; provided by other statutes.
416.1237 Assistance received on account of major disaster.
416.1238 Exclusion of certain housing assistance.
416.1239 Exclusion of State or local relocation assistance payments.
416.1240 Disposition of resources.
416.1242 Time limits for disposing of resources.
416.1244 Treatment of proceeds from disposition of resources.
416.1245 Exceptions to required disposition of real property.
416.1246 Disposal of resources at less than fair market value.
416.1247 Exclusion of a dedicated account in a financial institution.
416.1260 Special resource provision for recipients under a State plan.
416.1261 Application of special resource provision.
416.1262 Special resource provision applicable in cases involving essential persons.
416.1264 Spouse ineligible under a State plan in December 1973.
416.1266 Individual under special resource provision dies after December 1973.

Subpart M—Suspensions and Terminations

416.1321 Suspensions; general.
416.1322 Suspension due to failure to comply with request for information.
416.1323 Suspension due to excess income.
416.1324 Suspension due to excess resources.
416.1325 Suspension due to status as a resident of a public institution.
416.1326 Suspension for failure to comply with treatment for drug addiction or alcoholism.
416.1327 Suspension due to absence from the United States.
416.1328 Suspension due to refusal to accept vocational rehabilitation services.
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.
416.1330 Suspension due to failure to apply for and obtain other benefits.
416.1331 Termination of your disability or blindness payments.
416.1332 Termination of benefit for disabled individual: Exception.
416.1333 Termination at the request of the recipient.
416.1334 Termination due to death of recipient.
416.1335 Termination due to continuous suspension.
416.1336 Notice of intended action affecting recipient's payment status.
416.1337 Exceptions to the continuation of previously established payment level.
416.1338 If you are participating in a vocational rehabilitation program.

Subpart N—Determinations, Administrative Review Process, and Reopening of Determinations and Decisions

INTRODUCTION, DEFINITIONS, AND INITIAL DETERMINATIONS

416.1400 Introduction.
416.1401 Definitions.
416.1402 Administrative actions that are initial determinations.
416.1403 Administrative actions that are not initial determinations.
416.1404 Notice of the initial determination.
416.1405 Effect of an initial determination.

416.1406 Testing modifications to the disability determination procedures.

RECONSIDERATION

416.1407 Reconsideration—general.
416.1408 Parties to a reconsideration.
416.1409 How to request reconsideration.
416.1411 Good cause for missing the deadline to request review.
416.1413 Reconsideration procedures.
416.1413a Reconsiderations of initial determinations on applications.
416.1413b Reconsideration procedures for post-eligibility claims.
416.1413c Arrangement for conferences.
416.1414 Disability hearing—general.
416.1415 Disability hearing—disability hearing officers.
416.1416 Disability hearing—procedures.
416.1417 Disability hearing—disability hearing officer's reconsidered determination.
416.1418 Disability hearing—review of the disability hearing officer's reconsidered determination before it is issued.
416.1419 Notice of another person's request for reconsideration.
416.1420 Reconsidered determination.
416.1421 Effect of a reconsidered determination.
416.1422 Notice of a reconsidered determination.

EXPEDITED APPEALS PROCESS

416.1423 Expedited appeals process—general.
416.1424 When the expedited appeals process may be used.
416.1425 How to request expedited appeals process.
416.1426 Agreement in expedited appeals process.
416.1427 Effect of expedited appeals process agreement.
416.1428 Expedited appeals process request that does not result in agreement.

HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

416.1429 Hearing before an administrative law judge—general.
416.1430 Availability of a hearing before an administrative law judge.
416.1432 Parties to a hearing before an administrative law judge.
416.1433 How to request a hearing before an administrative law judge.
416.1435 Submitting evidence prior to a hearing before an administrative law judge.
416.1436 Time and place for a hearing before an administrative law judge.
416.1438 Notice of a hearing before an administrative law judge.
416.1439 Objections to the issues.
416.1440 Disqualification of the administrative law judge.
416.1441 Prehearing case review.
416.1442 Prehearing proceedings and decisions by attorney advisors.
416.1443 Responsibilities of the adjudication officer.

ADMINISTRATIVE LAW JUDGE HEARING PROCEDURES

416.1444 Administrative law judge hearing procedures—general.
416.1446 Issues before an administrative law judge.
416.1448 Deciding a case without an oral hearing before an administrative law judge.
416.1449 Presenting written statements and oral arguments.
416.1450 Presenting evidence at a hearing before an administrative law judge.
416.1451 When a record of a hearing before an administrative law judge is made.
416.1452 Consolidated hearings before an administrative law judge.
416.1453 The decision of an administrative law judge.
416.1455 The effect of an administrative law judge's decision.
416.1456 Removal of a hearing request from an administrative law judge to the Appeals Council.
416.1457 Dismissal of a request for a hearing before an administrative law judge.
416.1458 Notice of dismissal of a request for a hearing before an administrative law judge.
416.1459 Effect of dismissal of a request for a hearing before an administrative law judge.
416.1460 Vacating a dismissal of a request for a hearing before an administrative law judge.
416.1461 Prehearing and posthearing conferences.
416.1465 [Reserved]

APPEALS COUNCIL REVIEW

416.1466 Testing elimination of the request for Appeals Council review.
416.1467 Appeals Council review—general.
416.1468 How to request Appeals Council review.
416.1469 Appeals Council initiates review.
416.1470 Cases the Appeals Council will review.
416.1471 Dismissal by Appeals Council.
416.1472 Effect of dismissal of request for Appeals Council review.
416.1473 Notice of Appeals Council review.
416.1474 Obtaining evidence from Appeals Council.
416.1475 Filing briefs with the Appeals Council.
416.1476 Procedures before Appeals Council on review.
416.1477 Case remanded by Appeals Council.
416.1479 Decision of Appeals Council.
416.1481 Effect of Appeals Council's decision or denial of review.

416.1482 Extension of time to file action in Federal district court.

COURT REMAND CASES

416.1483 Case remanded by a Federal court.
416.1484 Appeals Council review of administrative law judge decision in a case remanded by a Federal court.
416.1485 Application of circuit court law.

REOPENING AND REVISING DETERMINATIONS AND DECISIONS

416.1487 Reopening and revising determinations and decisions.
416.1488 Conditions for reopening.
416.1489 Good cause for reopening.
416.1491 Late completion of timely investigation.
416.1492 Notice of revised determination or decision.
416.1493 Effect of revised determination or decision.
416.1494 Time and place to request further review or a hearing on revised determination or decision.

PAYMENT OF CERTAIN TRAVEL EXPENSES

416.1495 Payment of certain travel expenses—general.
416.1496 Who may be reimbursed.
416.1498 What travel expenses are reimbursable.
416.1499 When and how to claim reimbursement.

Subpart O—Representation of Parties

416.1500 Introduction.
416.1503 Definitions.
416.1505 Who may be your representative.
416.1506 Notification of options for obtaining attorney representation.
416.1507 Appointing a representative.
416.1510 Authority of a representative.
416.1515 Notice or request to a representative.
416.1520 Fee for a representative's services.
416.1525 Request for approval of a fee.
416.1528 Proceedings before a State or Federal court.
416.1535 Services in a proceeding under title XVI of the Act.
416.1540 Rules of conduct and standards of responsibility for representatives.
416.1545 Violations of our requirements, rules, or standards.
416.1550 Notice of charges against a representative.
416.1555 Withdrawing charges against a representative.
416.1565 Hearing on charges.
416.1570 Decision by hearing officer.
416.1575 Requesting review of the hearing officer's decision.
416.1576 Assignment of request for review of the hearing officer's decision.
416.1580 Appeals Council's review of hearing officer's decision.
416.1585 Evidence permitted on review.
416.1590 Appeals Council's decision.
416.1595 When the Appeals Council will dismiss a request for review.
416.1597 Reinstatement after suspension—period of suspension expired.
416.1599 Reinstatement after suspension or disqualification—period of suspension not expired.

Subpart P—Residence and Citizenship

416.1600 Introduction.
416.1601 Definitions and terms used in this subpart.
416.1603 How to prove you are a resident of the United States.
416.1610 How to prove you are a citizen or a national of the United States.
416.1615 How to prove you are lawfully admitted for permanent residence in the United States.
416.1618 When you are considered permanently residing in the United States under color of law.
416.1619 When you cannot be considered permanently residing in the United States under color of law.

Subpart Q—Referral of Persons Eligible for Supplemental Security Income to Other Agencies

GENERAL

416.1701 Scope of subpart.
416.1705 Definitions.

REFERRAL FOR VOCATIONAL REHABILITATION SERVICES

416.1710 Whom we refer and when.
416.1715 Effect of your rejecting vocational rehabilitation services.

REFERRAL FOR TREATMENT OF ALCOHOLISM OR DRUG ADDICTION

416.1720 Whom we refer.
416.1725 Effect of your failure to comply with treatment requirements for your drug addiction or alcoholism.

Subpart R—Relationship

416.1801 Introduction.

WHO IS CONSIDERED YOUR SPOUSE

416.1802 Effects of marriage on eligibility and amount of benefits.
416.1806 Whether you are married and who is your spouse.
416.1816 Information we need concerning marriage when you apply for SSI.
416.1821 Showing that you are married when you apply for SSI.

416.1826 Showing that you are not married when you apply for SSI.
416.1830 When we stop considering you and your spouse an eligible couple.
416.1832 When we consider your marriage ended.
416.1835 Information we need about separation or end of marriage after you become eligible for SSI.

WHO IS CONSIDERED A CHILD

416.1851 Effects of being considered a child.
416.1856 Who is considered a child.
416.1861 Deciding whether you are a child: Are you a student?
416.1866 Deciding whether you are a child: Are you the head of a household?

WHO IS CONSIDERED YOUR PARENT

416.1876 Effects a parent (or parents) can have on the child's benefits.
416.1881 Deciding whether someone is your parent or stepparent.

Subpart S—Interim Assistance Provisions

INTRODUCTION

416.1901 Scope of subpart S.
416.1902 Definitions.

AUTHORIZATIONS

416.1904 Authorization to withhold SSI benefits.
416.1906 When your authorization is in effect.
416.1908 When we need another authorization.

INTERIM ASSISTANCE AGREEMENTS

416.1910 Requirements for interim assistance agreement.

APPEALS

416.1920 Your appeal rights in the State.
416.1922 Your appeal rights in SSA.

Subpart T—State Supplementation Provisions; Agreement; Payments

416.2001 State supplementary payments; general.
416.2005 Administration agreements with SSA.
416.2010 Essentials of the administration agreements.
416.2015 Establishing eligibility.
416.2020 Federally administered supplementary payments.
416.2025 Optional supplementation: Countable income.
416.2030 Optional supplementation: Variations in payments.
416.2035 Optional supplementation: Additional State options.
416.2040 Limitations on eligibility.
416.2045 Overpayments and underpayments; federally administered supplementation.
416.2047 Waiver of State supplementary payments.
416.2050 Mandatory minimum State supplementation.
416.2055 Mandatory minimum supplementation reduced.
416.2060 Mandatory minimum supplementary payments not applicable.
416.2065 Mandatory minimum State supplementation: Agreement deemed.
416.2070 Mandatory supplementation: State compliance not applicable.
416.2075 Monitoring of mandatory minimum supplementary payments.
416.2090 State funds transferred for supplementary payments.
416.2095 Pass-along of Federal benefit increases.
416.2096 Basic pass-along rules.
416.2097 Combined supplementary/SSI payment levels.
416.2098 Supplementary payment levels.
416.2099 Compliance with pass-along.

Subpart U—Medicaid Eligibility Determinations

416.2101 Introduction.
416.2111 Conditions for our agreeing to make Medicaid eligibility determinations.
416.2116 Medicaid eligibility determinations.
416.2130 Effect of the agreement and responsibilities of States.
416.2140 Liability for erroneous Medicaid eligibility determinations.
416.2145 Services other than Medicaid determinations.
416.2161 Charges to States.
416.2166 Changing the agreement.
416.2171 Duration of agreement.
416.2176 Disagreements between a State and us.

Subpart V—Payments for Vocational Rehabilitation Services

GENERAL PROVISIONS

416.2201 General.
416.2202 Purpose and scope.
416.2203 Definitions.
416.2204 Participation by State VR agencies or alternate participants.
416.2206 Basic qualifications for alternate participants.

PAYMENT PROVISIONS

416.2208 Requirements for payment.
416.2209 Responsibility for making payment decisions.
416.2210 What we mean by ''SGA'' and by ''a continuous period of 9 months''.

416.2211 Criteria for determining when VR services will be considered to have contributed to a continuous period of 9 months.
416.2212 Payment for VR services in a case where an individual continues to receive disability or blindness benefits based on participation in an approved VR program.
416.2213 Payment for VR services in a case of VR refusal.
416.2214 Services for which payment may be made.
416.2215 When services must have been provided.
416.2216 When claims for payment for VR services must be made (filing deadlines).
416.2217 What costs will be paid.

ADMINISTRATIVE PROVISIONS

416.2218 Applicability of these provisions to alternate participants.
416.2219 Method of payment.
416.2220 Audits.
416.2221 Validation reviews.
416.2222 Confidentiality of information and records.
416.2223 Other Federal laws and regulations.
416.2227 Resolution of disputes.

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 1381–133d); 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 Commissioner. It also sets out the Commissioner'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; 62 FR 38454, July 18, 1997]

§416.105 Administration.

The Supplemental Security Income for the Aged, Blind, and Disabled program is administered by the Social Security Administration.

[51 FR 11718, Apr. 7, 1986, as amended at 62 FR 38454, July 18, 1997]

§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 Commissioner 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; 62 FR 38454, July 18, 1997]

§ 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) *Commissioner; Appeals Council; defined.* As used in this part:

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

(2) *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 Commissioner 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 Commissioner 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; 62 FR 38454, July 18, 1997]

§ 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. However, the first month for which you may receive SSI benefits is the month after the month in which you meet these eligibility requirements. (See § 416.501.) 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 416.216.

[64 FR 31972, June 15, 1999]

§ 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]

§ 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, you cannot become eligible for payment of SSI benefits until the month after the month in which you first become eligible for SSI benefits (see § 416.501). In addition, we usually determine the amount of your SSI benefits for a month based on your income in an earlier month (see § 416.420). Thus, it is possible for you to meet the eligibility requirements in a 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; 64 FR 31972, June 15, 1999]

§ 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 payment of benefits until the first day of the month following the day of your release from the institution.

(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) You reside throughout a month in a public institution that is a medical care facility where Medicaid (title XIX of the Social Security Act) pays a substantial part (more than 50 percent) of the cost of your care; you are a child under the age of 18 residing throughout a month in a public institution that is a medical care facility where a substantial part (more than 50 percent) of the cost of your care is paid under a health insurance policy issued by a private provider of such insurance; or, you are a child under the age of 18 residing throughout a month in a public institution that is a medical care facility where a substantial part (more than 50 percent) of the cost of your care is paid by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider of such insurance; 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 a substantial part (more than 50 percent) of the cost of your care; you are a child under the age of 18 residing for part of a month in a public institution and the rest of the month in a public institution or private medical facility where a substantial part (more than 50 percent) of the cost of your care is paid under a health insurance policy issued by a private provider of such insurance; or you are a child under the age of 18 residing for part of a month in a public institution and the rest of the month in a public institution or private medical facility where a substantial part (more than 50 percent) of the cost of your care is paid by a combination of Medicaid payments and payments made under a health insurance policy issued by a private provider; 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; 62 FR 1055, Jan. 8, 1997; 64 FR 31972, June 15, 1999]

§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 a substantial part (more than 50 percent) of the cost of your care or, if you are a child under age 18, reduced because of residence in a public or private institution which receives payments under a health insurance policy issued by a private provider, or a combination of Medicaid and a health insurance policy issued by a private provider, pay a substantial part (more than 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 a substantial part (more than 50 percent) of the cost of your care or, if you are a child under age 18, reduced because of residence in a public institution which receives payments under a health insurance policy issued by a private provider, or a combination of Medicaid and a health insurance policy issued by a private provider, pay a substantial part (more than 50 percent) of the cost of your care 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, as amended at 62 FR 1055, Jan. 8, 1997]

§ 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]

§ 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]

§ 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]

§ 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]

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 Commissioner 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 Commissioner 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 Commissioner 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; 62 FR 38454, July 18, 1997]

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 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 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; 64 FR 31972, June 15, 1999]

§ 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 to receive payment; 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; 64 FR 31972, June 15, 1999]

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) 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 can be paid starting with the first day of the month following the month the individual first meets all eligibility requirements for such benefits, including having filed an application. 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; 64 FR 31972, June 15, 1999]

§ 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 from the date it is filed 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, the earliest month for which we can pay you benefits is the month following the month that you first meet all the requirements.

(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 can pay you benefits only from the first day of the month following the month that you meet all the requirements based on the new application.

[64 FR 31973, June 15, 1999]

§ 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, the earliest month for which we can pay you benefits is the month following the month you filed the application. If you file an application after the month you first meet all the other requirements for eligibility, we cannot pay you for the month in which your application is filed or any months before that month. 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.

[64 FR 31973, June 15, 1999]

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]

§ 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]

§ 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]

§ 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 a substantial part (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 applies to persons who are in medical care facilities where a substantial part (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. This reduced SSI benefit rate also applies to children under age 18 who are in medical care facilities where a substantial part (more than 50 percent) of the cost of their care is paid by a health insurance policy issued by a private provider of such insurance, or where a substantial part (more than 50 percent) of the cost of their care is paid for by a combination of Medicaid payments and payments made under a

health insurance policy issued by a private provider of such insurance. 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 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) a substantial part (more than 50 percent) of the cost of their care; and

(3) Children under age 18 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 a substantial part (more than 50 percent) of the cost of their care is being paid under a health insurance policy issued by a private provider or by a combination of Medicaid and payments under a health insurance policy issued by a private provider.

(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; 62 FR 1056, Jan. 8, 1997]

§ 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 generally 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. We will use the benefit rate (see §§416.410 through 416.414), as increased by a cost-of-living adjustment, in determining the value of the one-third reduction or the presumed maximum value, to compute your SSI benefit amount for the first 2 months in which the cost-of-living adjustment is in effect. If you have been receiving 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 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. Z's SSI benefit amount is being determined for January (the current month). There has been a cost-of-living increase in SSI benefits effective January. Mr. Z's countable income in November is used to determine the benefit amount for January. In November, Mr. Z had in-kind support and maintenance valued at the presumed maximum value as described in §416.1140(a). We will use the January benefit rate, as increased by the COLA, to determine the value of the in-kind support and maintenance Mr. Z received in November when we determine Mr. Z's SSI benefit amount for January.

Example 3. 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 initial eligibility for payment or the first month of 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 initially eligible for payment of SSI benefits (see §416.501) or for the first month you again become eligible for SSI benefits after at least a month of ineligibility. Your payment for a first month of reeligibility after at least one-month of ineligibility will be prorated according to the number of days in the month that you are eligible beginning with the date on which you reattain eligibility.

Example: Mrs. Y applies for SSI benefits in September and meets the requirements for eligibility in that month. (We use Mrs. Y's countable income in September to determine if she is eligible for SSI in September.) The first month for which she can receive payment is October (see §416.501). We use Mrs. Y's countable income in October to determine the amount of her benefit for October. If Mrs. Y had been receiving SSI benefits through July, became ineligible for SSI benefits in August, and again became eligible for such benefits in September, we would use Mrs. Y's countable income in September to determine the amount of her benefit for September. In addition, the proration rules discussed above would also apply to determine the amount of benefits in September in this second situation.

(2) *Second month of initial eligibility for payment or second month of 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 for payment or the second month of reeligibility 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 payment of SSI benefits in October. Her benefit amount for November will be based on her countable income in October (first prior month).

(3) *Third month of initial eligibility for payment or third month of 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 for payment or the third month of reeligibility after at least a month of ineligibility.

Example: Mrs. Y was initially eligible for payment of SSI benefits in October. Her benefit amount for December will be based on her countable income in October (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) *Reliable information which is currently available for determining benefits.* The Commissioner has determined that no reliable information exists which is currently available to use in determining benefit amounts.

(1) *Reliable information.* For purposes of this section *reliable information* means payment information that is maintained on a computer system of records by the government agency determining the payments (e.g., Department of Veterans Affairs, Office of Personnel Management for Federal civil service information and the Railroad Retirement Board).

(2) *Currently available information.* For purposes of this section *currently available information* means information that is available at such time that it permits us to compute and issue a correct benefit for the month the information is pertinent.

(d) *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; 62 FR 30751, June 5, 1997; 63 FR 33546, June 19, 1998; 64 FR 31973, June 15, 1999]

§ 416.421 Determination of benefits; computation of prorated benefits.

(a) 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.

[51 FR 13493, Apr. 14, 1986, as amended at 64 FR 31973, June 15, 1999]

§ 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 of this part) in his home, the amount by which his rate of payment is increased is determined in accordance with §§ 416.220 through 416.223 and with 416.413 of this part. 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; 65 FR 16814, Mar. 30, 2000]

§ 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)); 31 U.S.C. 3720A.

§ 416.501 Payment of benefits: General.

Payment of SSI benefits will be made for the month after the month of initial eligibility and for each subsequent month provided all requirements for eligibility (see § 416.202) and payment (see § 416.420) are met. In the month the 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 first month following the date on which an application is filed or, if later, the first month following the date all conditions for eligibility are met.

[64 FR 31973, June 15, 1999]

§ 416.502 Manner of payment.

For the month an individual 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 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, as amended at 64 FR 31974, June 15, 1999]

§ 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.* We may pay a one-time emergency advance payment to an individual initially applying for benefits 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 federally administered State supplementary payment, if any (see § 416.2020), which apply for the month for which the 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 field office to an individual or spouse who is initially applying (see paragraph (b)(3) of this section), who is at least 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 all of the requirements for eligibility including 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 of this part).

(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 amount payable for the month for which 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 rules appropriate for the month for which the advance is paid, as explained in §416.420. Generally, the month for which the advance is paid is the month in which it is paid. However, if the advance is paid in the month the application is filed, the month for which the advance is paid is considered to be the first month of expected eligibility for payment of benefits.

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

(d) *Recovery of emergency advance payment where eligibility is established.* When an individual or spouse is determined to be eligible and retroactive payments are due, any emergency advance payment amounts are recovered in full from the first payment(s) certified to the United States Treasury. However, if no retroactive payments are due and benefits are only due in future months, any emergency advance payment amounts are recovered through proportionate reductions in those benefits over a period of not more than 6 months. (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, as amended at 64 FR 31974, June 15, 1999]

§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, and the additional rules in § 416.545 may apply. 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) *Additional rules for eligible individuals under age 18 who have a representative payee.* When an eligible individual under age 18 has a representative payee and receives less than the correct amount of SSI benefits, the additional rules in § 416.546 may apply.

(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; 61 FR 67205, Dec. 20, 1996]

§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 Commissioner) 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; 62 FR 38454, July 18, 1997]

§ 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) *Limited delay in payment of underpaid amount to eligible individual under age 18 who has a representative payee.* When the representative payee of an eligible individual under age 18 is required to establish a dedicated account pursuant to §§ 416.546 and 416.640(e), payment of past-due benefits which are otherwise due will be delayed until the representative payee has established the dedicated account as described in § 416.640(e). Once the account is established, SSA will deposit the past-due benefits payable directly to the account.

(e) *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, as amended at 61 FR 67205, Dec. 20, 1996]

§ 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. If the underpaid amount meets the formula in § 416.545 and one of the exceptions does not apply, the amount of any past-due benefits will be paid in installments.

(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.

(3) If an underpaid individual under age 18 is alive and has a representative payee and is due past-due benefits which meet the formula in § 416.546, SSA will pay the past-due benefits into the dedicated account described in § 416.640(e). If the underpaid individual dies before the benefits have been deposited into the account, we will follow the rules which apply to underpayments for the payment of any unpaid amount due to any eligible survivor of a deceased individual 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; 61 FR 67206, Dec. 20, 1996]

§ 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]

§416.545 Paying large past-due benefits in installments.

(a) *General.* Except as described in paragraph (c) of this section, when an individual is eligible for past-due benefits in an amount which meets the formula in paragraph (b) of this section, payment of these benefits must be made 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.* Installment payments must be made if the amount of the past-due benefits including any federally administered State supplementation, after applying §416.525, equals or exceeds 12 times the Federal Benefit Rate plus any federally administered State supplementation payable in a month to an eligible individual (or eligible individual and eligible spouse). These installment payments will be paid in not more than 3 installments and made at 6-month intervals. Except as described in paragraph (d) of this section, the amount of each of the first and second installment payments may not exceed the threshold amount of 12 times the maximum monthly benefit payable as described in this paragraph.

(c) *Exception—When installments payments are not required.* Installment payments are not required and the rules in this section do not apply if, when the determination of an underpayment is made, the individual is (1) afflicted with a medically determinable impairment which is expected to result in death within 12 months, or (2) ineligible for benefits and we determine that he or she is likely to remain ineligible for the next 12 months.

(d) *Exception—Increased first and second installment payments.* (1) The amount of the first and second installment payments may be increased by the total amount of the following debts and expenses:

(i) Outstanding debt for food, clothing, shelter, or medically necessary services, supplies or equipment, or medicine; or

(ii) Current or anticipated expenses in the near future for medically necessary services, supplies or equipment, or medicine, or for the purchase of a home.

(2) The increase described in paragraph (d)(1) of this section only applies to debts or expenses that are not subject to reimbursement by a public assistance program, the Secretary of Health and Human Services under title XVIII of the Act, a State plan approved under title XIX of the Act, or any private entity that is legally liable for payment in accordance with an insurance policy, pre-paid plan, or other arrangement.

[61 FR 67206, Dec. 20, 1996]

§416.546 Payment into dedicated accounts of past-due benefits for eligible individuals under age 18 who have a representative payee.

or purposes of this section, amounts subject to payment into dedicated accounts (see §416.640(e)) include the amounts described in §416.545(a) (1), (2), and (3).

(a) For an eligible individual under age 18 who has a representative payee and who is determined to be eligible for past-due benefits (including any federally administered State supplementation) in an amount which (after §416.525 is applied) exceeds six times the Federal Benefit Rate plus any federally administered State supplementation payable in a month, this unpaid amount must be paid into the dedicated account established and maintained as described in §416.640(e).

(b) After the account is established, the representative payee may (but is not required to) deposit into the account any subsequent past-due benefits (including any federally administered State supplementation) which are in an amount less than that specified in paragraph (a) of this section or any other funds representing an SSI underpayment which is equal to or exceeds the maximum Federal Benefit Rate.

(c) If the underpaid individual dies before all the benefits due have been deposited into the dedicated account, we will follow the rules which apply to underpayments for the payment of any unpaid amount due to any eligible survivor as described in § 416.542(b).

[61 FR 67206, Dec. 20, 1996]

§ 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. No funds properly deposited into a dedicated account (see §§ 416.546 and 416.640(e)) can be used to repay an overpayment while the overpaid individual remains subject to the provisions of those sections.

[55 FR 33669, Aug. 17, 1990; 55 FR 42148, Oct. 17, 1990; 61 FR 67206, Dec. 20, 1996]

§ 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]

§ 416.580 Referral of overpayments to the Department of the Treasury for tax refund offset—General.

(a) The standards we will apply and the procedures we will follow before requesting the Department of the Treasury to offset income tax refunds due taxpayers who have an outstanding overpayment are set forth in §§ 416.580 through 416.586 of this subpart. These standards and procedures are authorized by the Deficit Reduction Act of 1984 [31 U.S.C. § 3720A], as implemented through Department of the Treasury regulations at 31 CFR 285.2.

(b) We will use the Department of the Treasury tax refund offset procedure to collect overpayments that are certain in amount, past due and legally enforceable, and eligible for tax refund offset under regulations issued by the Secretary of the Treasury. We will use these procedures to collect overpayments only from individuals who are not currently entitled to monthly supplemental security income benefits under title XVI of the Act. We will refer an overpayment to the Secretary of the Treasury for offset against tax refunds no later than 10 years after our right to collect the overpayment first accrued.

[62 FR 49439, Sept. 22, 1997]

§ 416.581 Notice to overpaid individual.

A request for reduction of a Federal income tax refund will be made only after we determine that an amount is owed and past due and provide the overpaid individual with 60 calendar days written notice. Our notice of intent to collect an overpayment through Federal income tax refund offset will state:

(a) The amount of the overpayment;

(b) That unless, within 60 calendar days from the date of our notice, the overpaid individual repays the overpayment, sends evidence to us at the address given in our notice that the overpayment is not past due or not legally enforceable, or asks us to waive collection of the overpayment under section 1631(b)(1)(B) of the Act, we intend to seek collection of the overpayment by requesting that the Department of the Treasury reduce any amounts payable to the overpaid individual as refunds of Federal income taxes by an amount equal to the amount of the overpayment;

(c) The conditions under which we will waive recovery of an overpayment under section 1631(b)(1)(B) of the Act;

(d) That we will review any evidence presented that the overpayment is not past due or not legally enforceable;

(e) That the overpaid individual has the right to inspect and copy our records related to the overpayment as determined by us and will be informed as to where and when the inspection and copying can be done after we receive notice from the overpaid individual that inspection and copying are requested.

[62 FR 49439, Sept. 22, 1997]

§ 416.582 Review within SSA that an overpayment is past due and legally enforceable.

(a) *Notification by overpaid individual.* An overpaid individual who receives a notice as described in § 416.581 of this subpart has the right to present evidence that all or part of the overpayment is not past due or not legally enforceable. To exercise this right, the individual must notify us and present evidence regarding the overpayment within 60 calendar days from the date of our notice.

(b) *Submission of evidence.* The overpaid individual may submit evidence showing that all or part of the debt is not past due or not legally enforceable as provided in paragraph (a) of this section. Failure to submit the notification and evidence within 60 calendar days

will result in referral of the overpayment to the Department of the Treasury, unless the overpaid individual, within this 60-day time period, has asked us to waive collection of the overpayment under section 1631(b)(1)(B) of the Act and we have not yet determined whether we can grant the waiver request. If the overpaid individual asks us to waive collection of the overpayment, we may ask that evidence to support the request be submitted to us.

(c) *Review of the evidence.* After a timely submission of evidence by the overpaid individual, we will consider all available evidence related to the overpayment. We will make findings based on a review of the written record, unless we determine that the question of indebtedness cannot be resolved by a review of the documentary evidence.

[62 FR 49439, Sept. 22, 1997]

§416.583 Findings by SSA.

(a) Following the review of the record, we will issue written findings which include supporting rationale for the findings. Issuance of these findings concerning whether the overpayment or part of the overpayment is past due and legally enforceable is the final Agency action with respect to the past-due status and enforceability of the overpayment. If we make a determination that a waiver request cannot be granted, we will issue a written notice of this determination in accordance with the regulations in subpart E of this part. Our referral of the overpayment to the Department of the Treasury will not be suspended under §416.585 of this subpart pending any further administrative review of the waiver request that the individual may seek.

(b) Copies of the findings described in paragraph (a) of this section will be distributed to the overpaid individual and the overpaid individual's attorney or other representative, if any.

(c) If the findings referred to in paragraph (a) of this section affirm that all or part of the overpayment is past due and legally enforceable and, if waiver is requested and we determine that the request cannot be granted, we will refer the overpayment to the Department of the Treasury. However, no referral will be made if, based on our review of the overpayment, we reverse our prior finding that the overpayment is past due and legally enforceable or, upon consideration of a waiver request, we determine that waiver of our collection of the overpayment is appropriate.

[62 FR 49439, Sept. 22, 1997]

§416.584 Review of our records related to the overpayment.

(a) *Notification by the overpaid individual.* An overpaid individual who intends to inspect or copy our records related to the overpayment as determined by us must notify us stating his or her intention to inspect or copy.

(b) *Our response.* In response to a notification by the overpaid individual as described in paragraph (a) of this section, we will notify the overpaid individual of the location and time when the overpaid individual may inspect or copy our records related to the overpayment. We may also, at our discretion, mail copies of the overpayment-related records to the overpaid individual.

[62 FR 49439, Sept. 22, 1997]

§416.585 Suspension of offset.

If, within 60 days of the date of the notice described in §416.581 of this subpart, the overpaid individual notifies us that he or she is exercising a right described in §416.582(a) of this subpart and submits evidence pursuant to §416.582(b) of this subpart or requests a waiver under §416.550 of this subpart, we will suspend any notice to the Department of the Treasury until we have issued written findings that affirm that an overpayment is past due and legally enforceable and, if applicable, make a determination that a waiver request cannot be granted.

[62 FR 49440, Sept. 22, 1997]

§416.586 Tax refund insufficient to cover amount of overpayment.

If a tax refund is insufficient to recover an overpayment in a given year, the case will remain with the Department of the Treasury for succeeding years, assuming that all criteria for certification are met at that time.

[62 FR 49440, Sept. 22, 1997]

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;

(d) Notify us of any change in his or her circumstances that would affect performance of the payee responsibilities; and

(e) In cases in which the beneficiary is an individual under age 18 (including cases in which the beneficiary is an individual whose low birth weight is a contributing factor material to our determination that the individual is disabled), ensure that the beneficiary is and has been receiving treatment to the extent considered medically necessary and available for the condition that was the basis for providing benefits (See § 416.994a(i).)

[47 FR 30475, July 14, 1982, as amended at 62 FR 6420, Feb. 11, 1997]

§ 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.

(e) *Dedicated accounts for eligible individuals under age 18.* (1) When past-due benefit payments are required to be paid into a separate dedicated account (see §416.546), the representative payee is required to establish in a financial institution an account dedicated to the purposes described in paragraph (e)(2) of this section. This dedicated account may be a checking, savings or money market account subject to the titling requirements set forth in §416.645. Dedicated accounts may not be in the form of certificates of deposit, mutual funds, stocks, bonds or trusts.

(2) A representative payee shall use dedicated account funds, whether deposited on a mandatory or permissive basis (as described in §416.546), for the benefit of the child and only for the following allowable expenses—

(i) Medical treatment and education or job skills training;

(ii) If related to the child's impairment(s), personal needs assistance; special equipment; housing modification; and therapy or rehabilitation; or

(iii) Other items and services related to the child's impairment(s) that we determine to be appropriate. The representative payee must explain why or how the other item or service relates to the impairment(s) of the child.

(3) Representative payees must keep records and receipts of all deposits to and expenditures from dedicated accounts, and must submit these records to us upon our request, as explained in §§ 416.635 and 416.665.

(4) The use of funds from a dedicated account in any manner not authorized by this section constitutes a misapplication of benefits. These misapplied benefits are not an overpayment as defined in § 416.537; however, if we determine that a representative payee knowingly misapplied funds in a dedicated account, that representative payee shall be liable to us in an amount equal to the total amount of the misapplied funds.

(5) The restrictions described in this section and the income and resource exclusions described in §§ 416.1124(c)(20) and 416.1247 shall continue to apply until all funds in the dedicated account are depleted or eligibility for benefits terminates, whichever comes first. This continuation of the restrictions and exclusions applies in situations where funds remain in the account in any of the following situations—

(i) A child attains age 18, continues to be eligible and receives payments directly;

(ii) A new representative payee is appointed. When funds remaining in a dedicated account are returned to us by the former representative payee, the new representative payee must establish an account in a financial institution into which we will deposit these funds, even if the amount is less than that prescribed in § 416.546; or

(iii) During a period of suspension due to ineligibility as described in § 416.1321, administrative suspension, or a period of eligibility for which no payment is due.

[47 FR 30475, July 14, 1982, as amended at 61 FR 10278, Mar. 13, 1996; 61 FR 67206, Dec. 20, 1996]

§ 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 §§ 416.220 through 416.223 of this part.)

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.

[46 FR 5873, Jan. 21, 1981, as amended at 65 FR 16814, Mar. 30, 2000]

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.

(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 terms *medical equivalence* and *functional equivalence* and how we determine medical equivalence (and functional equivalence if you are a child);

(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 or, if you are a child, to reduce your functional limitations to the point that they are no longer marked and severe, and how we apply the rule in § 416.930.

(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; 62 FR 6420, Feb. 11, 1997]

§ 416.902 General definitions and terms for this subpart.

As used in this subpart—

Acceptable medical source refers to one of the sources described in § 416.913(a) who provides evidence about your impairments. It includes treating sources, nontreating sources, and nonexamining sources.

Adult means a person who is age 18 or older.

Child means a person who has not attained age 18.

Commissioner means the Commissioner of Social Security.

Disability redetermination means a redetermination of your eligibility based on disability using the rules for new applicants appropriate to your age, except the rules pertaining to performance of substantial gainful activity. For individuals who are working and for whom a disability redetermination is required, we will apply the rules in §§ 416.260 ff. In conducting a disability redetermination, we will not use the rules for determining whether disability continues set forth in § 416.994 or § 416.994a. (See § 416.987.)

Impairment(s) means a medically determinable physical or mental impairment or a combination of medically determinable physical or mental impairments.

Marked and severe functional limitations, when used as a phrase, means the standard of disability in the Social Security Act for children claiming SSI benefits based on disability and is a level of severity that meets or medically or functionally equals the severity of a listing in the Listing of Impairments in appendix 1 of subpart P of part 404 (the Listing). See §§ 416.906, 416.924, and 416.926a. The words ''marked'' and ''severe'' are also separate terms used throughout this subpart to describe measures of functional limitations; the term ''marked'' is also used in the listings. See §§ 416.924 and 416.926a. The meaning of the words ''marked'' and ''severe'' when used as part of the term *marked and severe functional limitations* is not the same as the meaning of the separate terms ''marked'' and ''severe'' used elsewhere in 20 CFR 404 and 416. (See §§ 416.924(c) and 416.926a(c).)

Medical sources refers to acceptable medical sources, or other health care providers who are not acceptable medical sources.

Nonexamining source means a physician, psychologist, or other acceptable medical source who has not examined you but provides a medical or other opinion in your case. At the administrative law judge hearing and Appeals Council levels of the administrative review process, it includes State agency medical and psychological consultants, other program physicians and psychologists, and medical experts we consult. See § 416.927.

Nontreating source means a physician, psychologist, or other acceptable medical source who has examined you but does not have, or did not have, an ongoing treatment relationship with you. The term includes an acceptable medical source who is a consultative examiner for us, when the consultative examiner is not your treating source. See § 416.927.

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, psychologist, or other acceptable medical source who provides you, or 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 an acceptable medical source when the medical evidence establishes that you see, or have seen, the source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required for your medical condition(s). We may consider an acceptable medical source who has treated or evaluated 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 or evaluation is typical for your condition(s). We will not consider an acceptable medical source to be your treating source if your relationship with the source is not based on your medical need for treatment or evaluation, but solely on your need to obtain a report in support of your claim for disability. In such a case, we will consider the acceptable medical source to be a nontreating source.

We or *us* refers to either the Social Security Administration or the State agency making the disability or blindness determination.

You or *your* means, as appropriate, the person who applies for benefits, the person for whom an application is filed,

or the person who is receiving benefits based on disability or blindness.

[56 FR 36962, Aug. 1, 1991, as amended at 58 FR 47577, Sept. 9, 1993; 62 FR 6420, Feb. 11, 1997; 62 FR 13733, Mar. 21, 1997; 65 FR 11878, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11878, Mar. 7, 2000, § 416.902 was amended by removing the terms ''Secretary'', ''Source of record'', and ''You'', revising the definitions of ''Medical sources'' and ''Treating source'', and adding definitions in the appropriate alphabetical order for the terms ''Acceptable medical source'', ''Nonexamining source'', ''Nontreating source'', and ''You or your'', effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 416.902 General definitions and terms for this subpart.

* * * * *

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.

* * * * *

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.

* * * * *

You refers to the person who has applied for or is receiving benefits based on disability or blindness.

DETERMINATIONS

§ 416.903 Who makes disability and blindness determinations.

(a) *State agencies.* State agencies make disability and blindness determinations for the Commissioner 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 Commissioner 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—

(1) Any person living in a State which is not making for the Commissioner 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 Commissioner 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 Commissioner 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; 62 FR 38454, July 18, 1997]

§ 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 have a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the preceding sentence, if you file a new application for benefits and you are engaging in substantial gainful activity, we will not consider you disabled. We discuss our rules for determining disability in children who file new applications in §§416.924 through 416.924c and §§416.925 through 416.926a.

[62 FR 6421, Feb. 11, 1997]

§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) If you are an adult:

(1) 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, unless the disability redetermination rules in §416.987(b) apply to you.

(2) If the disability redetermination rules in § 416.987 apply to you, a disabling impairment is an impairment or combination of impairments that meets the requirements in §§ 416.920 (c) through (f).

(b) If you are a child, a disabling impairment is an impairment (or combination of impairments) that causes marked and severe functional limitations. This means that the impairment or combination of impairments:

(1) Must meet or medically or functionally equal the requirements of a listing in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, or

(2) Would result in a finding that you are disabled under § 416.994a.

(c) In determining whether you have a disabling impairment, earnings are not considered.

[62 FR 6421, Feb. 11, 1997]

EVIDENCE

§ 416.912 Evidence of your impairment.

(a) *General.* In general, you have to prove to us 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). If material to the determination whether you are blind or disabled, medical and other evidence must be furnished about the effects of your impairment(s) on your ability to work, or if you are a child, on your functioning, 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, 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 experts we consult based on their review of the evidence in your case record. See §§ 416.927(f)(2) and (f)(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, or, if you are a child, your functioning. 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, as amended at 62 FR 6421, Feb. 11, 1997; 65 FR 11878, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11878, Mar. 7, 2000, §416.912 was amended by revising paragraph (b)(6), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§416.912 Evidence of your impairment.

* * * * *

(b) * * *

(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).

* * * * *

§ 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 acceptable 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.* At the administrative law judge and Appeals Council levels, we will consider residual functional capacity assessments made by State agency medical and psychological consultants and other program physicians and psychologists to be ''statements about what you can still do'' made by nonexamining physicians and psychologists based on their review of the evidence in the case record. Statements about what you can still do (based on the acceptable 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 as follows (See §§ 416.927 and 416.945(c)):

(1) If you are an adult, the acceptable 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;

(2) If you are an adult, in cases of mental impairment(s), the acceptable 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; and

(3) If you are a child, the acceptable medical source's opinion about your functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli).

(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; 62 FR 6421, Feb. 11, 1997; 65 FR 11878, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11878, Mar. 7, 2000, §416.913 was amended by revising the first sentence of paragraph (b)(6) and paragraph (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§416.913 Medical evidence of your impairment.

* * * * *

(b) * * *

(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). * * *

(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 functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli).

* * * * *

§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 cooperate 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 source or another medical 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, as amended at 65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, §416.919 was amended by revising the first sentence, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§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. * * *

§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, or, if you are a child, your functioning, but the current severity of your impairment is not established.

[56 FR 36964, Aug. 1, 1991, as amended at 62 FR 6421, Feb. 11, 1997]

§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.

(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 medical source 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, as amended at 65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919g was amended by revising the last sentence of paragraph (a) and the first sentence of paragraph (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 416.919g Who we will select to perform a consultative examination.

(a) * * * For a more complete list of medical sources, see § 416.913(a).

* * * * *

(c) The physician or psychologist we choose may use support staff to help perform the consultative examination. * * *

§ 416.919h Your treating source.

When in our judgment your treating source 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 source will be the preferred source to do the purchased examination. Even if only a supplemental test is required, your treating source is ordinarily the preferred source.

[65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919h was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 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 medical source other than your treating source for a purchased examination or test in situations including, but not limited to, the following situations:

(a) Your treating source prefers not to perform such an examination or does not have the equipment to provide the specific data needed;

(b) There are conflicts or inconsistencies in your file that cannot be resolved by going back to your treating source;

(c) You prefer a source other than your treating source and have a good reason for your preference;

(d) We know from prior experience that your treating source may not be a productive source, *e.g.*, he or she has consistently failed to provide complete or timely reports.

[65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919i was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 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 medical source designated to perform the consultative examination.

You or your representative may object to your being examined by a medical source we have designated to perform a consultative examination. If there is a good reason for the objection, we will schedule the examination with another medical source. A good reason may be that the medical source we designated had previously represented an interest adverse to you. For example, the medical source 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 medical source's office location (*e.g.*, 2nd floor, no elevator), travel restrictions, and whether the medical source had examined you in connection with a previous disability determination or decision that was unfavorable to you. If your objection is that a medical source 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 medical source while a review is being conducted. We will handle any objection to use of the substitute medical source in the same manner. However, if we had previously conducted such a review and found that the reports of the medical source in question conformed to our guidelines, we will not change your examination.

[65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, §416.919j was revised, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§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, and stress tests) from a medical source.

(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, as amended at 65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919k was amended by revising the introductory text, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 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.

* * * * *

§ 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 source 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 medical source designated to perform the consultative examination.

[56 FR 36966, Aug. 1, 1991, as amended at 65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919m was amended by revising the first and last sentences, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 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. * * * The responsibility for deciding whether to perform the examination rests with the consultative examining physician or psychologist.

§ 416.919n Informing the medical source of examination scheduling, report content, and signature requirements.

The medical sources 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 medical sources who perform consultative examinations at the time we first contact them, and at subsequent appropriate intervals, of the following obligations:

(a) *Scheduling.* In scheduling full consultative examinations, sufficient time should be allowed to permit the medical source 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 your residual functional capacity (if you are an adult) or your functioning (if you are a child). The report should reflect your statement of your symptoms, not simply the medical source's statements or conclusions. The medical source'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. If you are an adult, this statement should describe the opinion of the medical source 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 medical source 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. If you are a child, this statement should describe the opinion of the medical source about your functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli). Although we will ordinarily request, as part of the consultative examination process, a medical source statement about what you can still do despite your impairment(s), the absence of such a statement in a consultative examination report will not make the report incomplete. See § 416.927; and

(7) In addition, the medical source 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 medical source 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 medical source who actually performed the examination. This attests to the fact that the medical source 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 medical source on a report annotated ''not proofed'' or ''dictated but not read'' is not acceptable. A rubber stamp signature of a medical source or the medical source's signature entered by any other person is not acceptable.

[56 FR 36966, Aug. 1, 1991, as amended at 62 FR 6421, Feb. 11, 1997; 62 FR 13733, Mar. 21, 1997; 65 FR 11879, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11879, Mar. 7, 2000, § 416.919n was amended by revising the section heading and the first and last sentences of the introductory text, adding a heading to paragraph (a), revising the first sentence of paragraph (a) introductory text, revising the last two sentences of paragraph (b), revising the second and third sentences of and adding two sentences at the end of paragraph (c)(6), and revising paragraphs (c)(7) and (e), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 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. * * * 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. * * *

* * * * *

(b) * * * 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) * * *

(6) * * * If you are an adult, 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. If you are a child, this statement should describe the opinion of the consultative physician or psychologist about your functional limitations in learning, motor functioning, performing self-care activities, communicating, socializing, and completing tasks (and, if you are a newborn or young infant from birth to age 1, responsiveness to stimuli); 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.

* * * * *

(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.

§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 medical source 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 medical source who performed the original examination cannot be obtained because the medical source is out of the country for an extended period of time, or on an extended vacation, seriously ill, deceased, or for any other reason, the consultative examination will be rescheduled with another medical source:

(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, as amended at 65 FR 11880, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11880, Mar. 7, 2000, §416.919o was amended by revising the last sentence of paragraph (a) introductory text and the last sentence of paragraph (b) introductory text, effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§416.919o When a properly signed consultative examination report has not been received.

* * * * *

(a) * * * 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.

* * * * *

(b) * * * 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.

* * * * *

§ 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 medical source who performed the consultative examination, give an explanation of our evidentiary needs, and ask that the medical source furnish the missing information or prepare a revised report.

(c) With your permission, or when the examination discloses new diagnostic information or test results that reveal a potentially life-threatening situation, we will refer the consultative examination report to your treating source. When we refer the consultative examination report to your treating source 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, as amended at 65 FR 11880, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11880, Mar. 7, 2000, § 416.919p was amended by revising paragraphs (b) and (c), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 416.919p Reviewing reports of consultative examinations.

* * * * *

(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.

* * * * *

§ 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 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 medical sources. 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, as amended at 65 FR 11880, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11880, Mar. 7, 2000, § 416.919s was amended by revising paragraph (e)(2) and the first sentence of paragraph (f)(6), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 416.919s Authorizing and monitoring the consultative examination.

* * * * *

(e) * * *

(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

* * * * *

(f) * * *

(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. * * *

* * * * *

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) *Steps in evaluating disability.* We consider all relevant 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 functioning. We will also evaluate any limitations in your functioning that result from your symptoms, including pain (see § 416.929). When you file a new application for benefits, we use the evaluation process set forth in (b) through (d) 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, medically equals, or functionally equals in severity any impairment that is listed in appendix 1 of subpart P of part 404 of this chapter. If you have such an impairment(s), and it meets the duration requirement, we will find that you are disabled. If you do not have such an impairment(s), or if it does not meet the duration requirement, we will find that you are not disabled.

(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 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.)

(c) *You must have a severe impairment(s).* If your impairment(s) is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations, we will find that you do not have a severe impairment(s) and are, therefore, not disabled.

(d) *Your impairment(s) must meet, medically equal, or functionally equal in severity a listed impairment in appendix 1.* An impairment(s) causes marked and severe functional limitations if it meets or medically equals in severity the set of criteria for an impairment listed in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, or if it is functionally equal in severity to a listed impairment.

(1) Therefore, if you have an impairment(s) that is listed in appendix 1, or is medically or functionally equal in severity to a listed impairment, and that meets the duration requirement, we will find you disabled.

(2) If your impairment(s) does not meet the duration requirement, or does not meet, medically equal, or functionally equal in severity a listed impairment, we will find that you are not disabled.

(3) We explain our rules for deciding whether an impairment(s) meets a listing in § 416.925. Our rules for how we decide whether an impairment(s) medically equals a listing are set forth in § 416.926. Our rules for deciding whether an impairment(s) functionally equals a listing are set forth in § 416.926a.

(e) *If you attain age 18 after you file your disability application but before we make a determination or decision.* For the period during which you are under age 18, we will evaluate whether you are disabled using the rules in this section. For the period starting with the day you attain age 18, we will evaluate whether you are disabled using the disability rules we use for adults filing new claims, in § 416.920.

(f) *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.

(g) *How we will explain our findings.* When we make an initial or reconsidered determination whether you are disabled under this section or whether your disability continues under §416.994a (except when a disability hearing officer makes the reconsideration determination), we will complete a standard form, Form SSA–538, Childhood Disability Evaluation Form. The form outlines the steps of the sequential evaluation process for individuals who have not attained age 18. In these cases, the State agency medical or psychological consultant (see §416.1016) or other designee of the Commissioner has overall responsibility for the content of the form and must sign the form to attest that it is complete and that he or she is responsible for its content, including the findings of fact and any discussion of supporting evidence. Disability hearing officers, administrative law judges, and the administrative appeals judges on the Appeals Council (when the Appeals Council makes a decision) will not complete the form but will indicate their findings at each step of the sequential evaluation process in their determinations or decisions.

[58 FR 47577, Sept. 9, 1993, as amended at 62 FR 6421, Feb. 11, 1997]

§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(c)). 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 cause marked and severe functional limitations. 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 with a listed impairment to determine whether you have an impairment(s) that medically or functionally equals the severity of 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) 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) *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 or combination of impairments causes functional limitations. 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).

(c) *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 that allow the child to compensate for the impairment(s) and, thus, to function 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 as set forth in this section and §§ 416.924 and 416.924c.

(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 appropriate for them are those that are also appropriate for adults. Older adolescents generally also share with the youngest adults the same abilities to adapt to work-related activities despite a severe impairment(s). By the age of adolescence, children have developed basic physical 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 (c)(1) of this section, we also recognize that adolescents may experience a variety of impairments with different effects on their functioning. For instance, a child born with a degenerative disorder will experience a worsening of its effects as he or she grows older so that functioning may be more limited for the older child than it is for a younger child with the same illness or disorder.)

[58 FR 47578, Sept. 9, 1993, as amended at 62 FR 6422, Feb. 11, 1997]

§416.924b Functioning in children.

(a) *General.* When we evaluate whether your impairment(s) is severe and, if so, whether it causes marked and severe functional limitations, we will consider all of your mental and physical limitations that result from your impairment(s).

(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 most important as 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 most important as 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 contexts such as school, work, vocational programs, and organized activities. Ordinarily, inability to perform work-related activities is most important as an indicator of functional limitations in adolescents aged 16 to attainment of age 18.

[58 FR 47580, Sept. 9, 1993, as amended at 62 FR 6423, Feb. 11, 1997]

§ 416.924c Other factors we will consider.

(a) *General.* When we evaluate whether your impairment(s) is severe, and if so, whether it causes marked and severe functional limitations, 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 your functional limitations, 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 functioning. 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 whether you have a severe impairment(s) and, if so, whether it meets or medically or functionally equals in severity any listing, and is therefore disabling. 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 are disabled, 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 functioning on a longitudinal basis, or whether the frequency of your outpatient care affects your functioning.

(c) *Effects of medication.* We will consider the effects of medication on your symptoms, signs, and laboratory findings, including your functioning. 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 any functional limitations which may nevertheless persist are marked and severe, 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 serious 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 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 functioning 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 functioning 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 functioning, even though you may still have functional limitations (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 functioning with an adaptation, we will consider the degree to which the adaptation enables you to function and any functional limitations that nevertheless persist.

(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 therapy, although intended to improve your functioning in some ways, may also interfere with your functioning in other ways. If you receive frequent therapy at school during a normal school day, it may or may not interfere significantly with your functioning. If you must frequently interrupt your activities at school or at home for therapy, these interruptions may interfere with your functioning. We will consider the frequency of any therapy that you must have, how long you have needed the therapy or will need the therapy, and whether it interferes with your 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 functioning. 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 functioning in a regular classroom setting. 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 disabled.

(h) *Treatment and intervention, in general.* With adequate treatment or intervention, some children not only have their symptoms and signs reduced, but also maintain, return to or achieve a level of functioning that is not disabling. Treatment or intervention may prevent, eliminate, or reduce functional limitations; if such limitations were disabling in the absence of treatment or intervention, treatment or intervention may eliminate them or reduce them so that they are not disabling. 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.

[62 FR 6423, Feb. 11, 1997]

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 that are considered severe enough to prevent an adult from doing any gainful activity or, for a child, that causes marked and severe functional limitations. 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. Although the severity criteria in part B of the Listing of Impairments are expressed in different ways for different impairments, the level of severity for impairments listed in part B is intended to be the same as that expressed in the functional severity criteria of the childhood mental disorders listings. (See listings 112.01 ff. of appendix 1 of subpart P of part 404 of this chapter.) Therefore, in general, a child's impairment(s) is of ''listing-level severity'' if it causes marked limitations in two broad areas of functioning or extreme limitations in one such area. (See § 416.926a for definition of the terms *marked* and *extreme* as they apply to children.) However, when we decide whether your impairment(s) meets the requirements for any listed impairment, we will decide that your impairment is of ''listing-level severity'' even if it does not result in marked limitations in two broad areas of functioning, or extreme limitations in one such area, if the listing that we apply does not require such limitations to establish that an impairment(s) is disabling.

(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; 62 FR 6424, Feb. 11, 1997; 62 FR 13539, Mar. 21, 1997]

§416.926 Medical equivalence for adults and children.

(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 corresponding medical criteria shown for any listed impairment. When we make a finding regarding medical equivalence, we will consider all relevant evidence in your case record. Medical equivalence can be found in two ways:

(1)(i) If you have an impairment that is described in the Listing of Impairments in appendix 1 of subpart P of part 404 of this chapter, but—

(A) You do not exhibit one or more of the medical findings specified in the particular listing, or

(B) You exhibit all of the medical findings, but one or more of the findings is not as severe as specified in the listing;

(ii) We will nevertheless find that your impairment is medically 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 medically equivalent to a listing, we will compare your medical findings with those for closely analogous listed impairments. If the medical findings related to your impairment(s) are at least of equal medical significance to those of a listed impairment, we will find that your impairment(s) is medically equivalent to the analogous listing.

(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 Commissioner in deciding medical equivalence. (See §416.1016.)

(c) *Who is a designated medical or psychological consultant.* A medical or psychological consultant designated by the Commissioner 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.)

(d) *Responsibility for determining medical equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see §416.1016) has the overall responsibility for determining medical equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining medical equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration 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

medical equivalence rests with the Administrative Law Judge or Appeals Council.

[45 FR 55621, Aug. 20, 1980, as amended at 52 FR 33928, Sept. 9, 1987; 56 FR 5561, Feb. 11, 1991; 62 FR 6424, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997]

§ 416.926a Functional equivalence for children.

(a) *General.* If your impairment or combination of impairments does not meet, or is not medically equivalent in severity to, any listed impairment in appendix 1 of subpart P of part 404 of this chapter, we will assess all functional limitations caused by your impairment(s), i.e., what you cannot do because of your impairment(s), to determine if your impairment(s) is functionally equivalent in severity to any listed impairment that includes disabling functional limitations in its criteria. 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 produce marked and severe functional limitations. If the functional limitation(s) caused by your impairment(s) is the same as the disabling functional limitation(s) caused by a listed impairment, we will find that your impairment(s) is equivalent in severity to that listed impairment, even if your impairment(s) is not medically related to the listed impairment. When we make a determination or decision using this rule, the primary focus will be on whether your functional limitations are disabling, as long as there is a direct, medically determinable cause for these limitations. As with any disabling impairment, the duration requirement must also be met (see §§ 416.909 and 416.924(a)).

(b) *How we determine functional equivalence.* We will compare any functional limitations resulting from your impairment(s) with the disabling functional limitations of any listed impairment in part A or part B of the Listing that includes the same functional limitations. The listing we use for comparison need not be medically related to your impairment(s). In paragraphs (b)(1) through (b)(4) of this section we explain the methods we may use to decide that your impairment(s) is functionally equivalent in severity to a listing. There is no set order in which we must consider these methods and we may not consider them all if we find that your impairment(s) is functionally equivalent in severity to a listed impairment. We will use any method that is appropriate to, or best describes, your impairment(s) and functional limitations. However, we will consider all of the methods before we determine that your impairment(s) is *not* functionally equivalent in severity to any listed impairment. At the initial and reconsideration levels (except when a disability hearing officer makes the reconsideration determination), we will also complete a standard form, Form SSA–538, Childhood Disability Evaluation Form, to show how we determined whether your impairment(s) is functionally equivalent in severity to a listed impairment. (See § 416.924(g).)

(1) *Limitation of specific functions.* We may find that your impairment(s) is functionally equivalent in severity to a listed impairment because of extreme limitation of one specific function, such as walking or talking. (See paragraph (c) of this section for an explanation of the term ''extreme.'') Some listings also include criteria requiring limitation of more than one specific function, such as limitations in walking *and* talking; each limitation in itself is not enough to show disability, but the combination of limitations establishes marked and severe functional limitations. If you have a limitation of a combination of specific functions that are the same as those in such a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

(2) *Broad areas of development or functioning.* Instead of looking at limitation of specific functions, we may evaluate the effects of your impairment(s) in broad areas of development or functioning, such as social functioning, motor functioning, or personal functioning (i.e., self-care) and determine if your functional limitations are equivalent in severity to the disabling functional limitations in listing 112.12 or listing 112.02. If you have extreme

limitations in one area of functioning or marked limitation in two areas of functioning, we will find that your impairment(s) is functionally equivalent in severity to a listed impairment. We explain the broad areas of development or functioning we consider and what the terms ''extreme'' and ''marked'' mean in paragraph (c) of this section.

(3) *Episodic impairments.* If you have a chronic impairment(s) that is characterized by frequent illnesses or attacks, or by exacerbations and remissions, we may evaluate your functional limitations using the methods in paragraphs (b)(1) and (b)(2) of this section. However, your functional limitations may vary and we may not be able to use the methods in paragraphs (b)(1) and (b)(2) of this section. Instead, we may compare your functional limitation(s) to those in any listing for a chronic impairment with similar episodic criteria to determine if your impairment(s) has such a serious impact on your functioning over time that it is functionally equivalent in severity to one of those listings. Limitations that are characteristic of episodic impairments are not necessarily related to a single, specific function. Episodes of disabling functional limitations may occur with specified frequency despite treatment. If your episodic impairment(s) produces disabling functional limitations that are the same as the disabling functional limitations of a listed impairment with similar episodic criteria, we will find that you are disabled even though you may be able to function adequately between episodes.

(4) *Limitations related to treatment or medication effects.* Some impairments require treatment over a long period of time (i.e., at least a year) and the treatment itself (e.g., multiple surgeries) causes marked and severe functional limitations. Marked and severe functional limitations may also result from the combined effects of limitations caused by ongoing treatment and limitations caused by an impairment(s). In many cases, we will be able to evaluate such limitations using the methods for evaluating specific functions or broad areas of development or functioning in paragraphs (b)(1) and (b)(2) of this section. But we may also compare your functional limitations(s) to criteria in listings based on treatment (including side effects of medication) that is itself disabling or that contributes to functional limitations. If treatment of your impairment(s) produces functional limitations that are the same as the disabling functional limitations of a listed impairment, we will find that your impairment(s) is functionally equivalent in severity to that listing.

(c) *Broad areas of development or functioning.* When we determine functional equivalence based on broad areas of development or functioning, we will evaluate the functional effects of your impairment(s) in several areas of development or functioning to determine if your functional limitations are equivalent in severity to the disabling functional limitations of listing 112.12 or listing 112.02. However, instead of referring to the areas of development or functioning in those listings, we will refer to the areas of development or functioning described in paragraphs (c)(4) and (c)(5) of this section. (We describe the areas in general terms in paragraph (c)(4) and then in detail as they apply to specific age groups in paragraph (c)(5).) If you have marked limitations in two areas of development or functioning, or extreme limitation in one area, we will find that your impairment(s) is functionally equivalent in severity to listing 112.12 or listing 112.02, even if your impairment(s) is a physical impairment(s) or a combination of physical and mental impairments. We explain the meaning of the terms ''marked limitation'' and ''extreme limitation'' in paragraph (c)(3) of this section.

(1) *How we use the areas of development or functioning.* (i) When we make a finding about functional equivalence, we will consider the extent of your functional limitations in the areas affected by your impairment(s). We will also consider how your limitation(s) in one area affects your development or functioning in other areas.

(ii) In some children, some physical impairments will be evaluated most appropriately only in the areas of motor development or motor functioning. In others, the effects will be more global. If you have a physical impairment(s) that causes a functional

limitation(s) not addressed solely in the area of motor development or motor functioning, we will consider the effects of your impairment in all relevant areas in which you have limitations from the impairment(s). A physical impairment(s) may cause limitations in any or all of the areas of development or functioning.

(2) *Other considerations.* When we assess your functioning, we will consider all information in your case record that can help us determine the effect 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, and other relevant factors (see §§ 416.924a through 416.924c). We will consider whether any help that you need from others to enable you to do any particular activity (e.g., dressing) is appropriate to your age.

(3) *Definitions of ''marked'' and ''extreme'' limitations*—(i) *Marked limitation* means—(A) When standardized tests are used as the measure of functional abilities, a valid score that is two standard deviations or more below the norm for the test (but less than three standard deviations); or

(B) For children from birth to attainment of age 3, functioning at more than one-half but not more than two-thirds of chronological age; or

(C) For children from age 3 to attainment of age 18, ''more than moderate'' and ''less than extreme.'' Marked limitation may arise when several activities or functions are limited or even when only one is limited as long as the degree of limitation is such as to interfere seriously with the child's functioning.

(ii) *Extreme limitation* means—

(A) When standardized tests are used as the measure of functional abilities, a valid score that is three standard deviations or more below the norm for the test; or

(B) For children from birth to attainment of age 3, functioning at one-half chronological age or less; or

(C) For children from birth to attainment of age 18, no meaningful functioning in a given area. There may be extreme limitation when several activities or functions are limited or even when only one is limited.

(4) *Areas of development or functioning.* The following are the areas of development or functioning that may be addressed in a finding of functional equivalence.

(i) *Cognition/communication:* The ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to retain and recall information, images, events, and procedures during the process of thinking. The ability or inability to comprehend and produce language (e.g., vocabulary and grammar) in order to communicate (e.g., to respond, as in answering questions, following directions, acknowledging the comments of others; to request, as in demanding action, meeting needs, seeking information, requesting clarification, initiating interaction; to comment, as in sharing information, expressing feelings and ideas, providing explanations, describing events, maintaining interaction, using hearing that is adequate for conversation, and using speech (articulation, voice, and fluency) that is intelligible.

(ii) *Motor:* The ability or inability to use gross and fine motor skills to relate to the physical environment and serve one's physical purposes. It involves general mobility, balance, and the ability to perform age-appropriate physical activities involved in play, physical education, sports, and physically related daily activities other than self-care (see Personal area).

(iii) *Social:* The ability or inability to form and maintain relationships with other individuals and with groups; e.g., parents, siblings, neighborhood children, classmates, teachers. Ability is manifested in responding to and initiating social interaction with others, sustaining relationships, and participating in group activities. It involves cooperative behaviors, consideration for others, awareness of others' feelings, and social maturity appropriate to a child's age. Ability is also manifested in the absence of inappropriate externalized actions (e.g., running away, physical aggression—but not

self-injurious actions, which are evaluated in the personal area of functioning), and the absence of inappropriate internalized actions (e.g., social isolation, avoidance of interpersonal activities, mutism). Social functioning in play, school, and work situations may involve interactions with adults, including responding appropriately to persons in authority (e.g., teachers, coaches, employers) or cooperative behaviors involving other children.

(iv) *Responsiveness to stimuli (birth to age 1 only):* The ability or inability to respond appropriately to stimulation (visual, auditory, tactile, vestibular, proprioceptive).

(v) *Personal (age 3 to age 18 only):* The ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., feeding, dressing, toileting, bathing; maintaining personal hygiene, proper nutrition, sleep, health habits; adhering to medication or therapy regimens; following safety precautions).

(vi) *Concentration, persistence, or pace (age 3 to age 18 only):* The ability or inability to attend to, and sustain concentration on, an activity or task, such as playing, reading, or practicing a sport, and the ability to perform the activity or complete the task at a reasonable pace.

(5) *Descriptions for specific age groups*—(i) *Newborns and young infants (birth to attainment of age 1).* Children in this age group are evaluated in terms of four areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (birth to attainment of age 1):* Your ability or inability to show interest in, and actively seek interaction with, your environment, first randomly, then through trial-and-error, and finally with deliberate and purposeful intent. Your ability or inability to first recognize, and then attach meaning to, routine situations and events and gradually to everyday sounds and eventually to familiar words. Your ability or inability to vocalize, both imitatively and spontaneously, using vowels and later consonants, first in isolation, and then in increasingly longer babbling strings.

(B) *Motor development (birth to attainment of age 1):* Your ability or inability to explore and manipulate your environment by moving your body and by using your hands; e.g., by increasingly controlling position and movement of head, sitting with support, creeping or crawling, pulling to standing position, walking with hand held, standing alone briefly, waving small rattle, reaching for or grasping objects, transferring toys, picking up small objects, attempting to scribble.

(C) *Social development (birth to attainment of age 1):* Your ability or inability to form and maintain intimate relationships, and to respond to, and eventually initiate reciprocal interactions with, your primary caregivers (e.g., through games such as pat-a-cake, peek-a-boo, so big). Your ability or inability to begin to regulate the behavior of others through intentional behavior (e.g., gestures, vocalizations). Your ability or inability to recognize and produce a variety of emotional cues (e.g., facial expressions, vocal tone changes).

(D) *Responsiveness to stimuli (birth to attainment of age 1):* Your ability or inability to form patterns of self-regulation, i.e., to recognize internal cues (e.g., hunger, pain), and to organize external experiences (e.g., light, sound, temperature, movement), and to regulate your reactions to them (e.g., brightening in response to sights and sounds, enjoying being touched or stroked or held, enjoying gentle movement in space (''rock-a-bye-baby'')).

(ii) *Older infants and toddlers (age 1 to attainment of age 3):* Children in this age group are evaluated in terms of three areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (age 1 to attainment of age 3):* Your ability or inability to understand by responding to increasingly complex requests, instructions, and questions; to refer to yourself and things around you by pointing and eventually by naming; to form concepts and to solve simple problems through purposeful experimentation (e.g., disassembling toys), imitation (immediate and delayed), and constructive play (e.g., putting

things in and out of containers, building with blocks, exploring spaces); to demonstrate your knowledge of objects, actions, and situations you have encountered through pretend play activities; to spontaneously communicate your wishes or needs by using gestures, an increasing number of intelligible words, and eventually grammatically correct simple sentences and questions with increasingly rich and broad vocabulary.

(B) *Motor development (age 1 to attainment of age 3):* Your ability or inability to move in your environment using your body with steadily increasing dexterity and independence from support by others, and your increasing ability to manipulate small objects and to use your hands to do, or to get, something that you want or need.

(C) *Social development (age 1 to attainment of age 3):* Your ability or inability to exhibit normal dependence upon, and intimacy with, your primary caregivers, as well as increasing independence from them; to initiate and respond to a variety of emotional cues; to regulate and organize emotions and behaviors. Your ability or inability to be interested in initiating and maintaining interactions with others, first during brief, yet frequent encounters, and gradually increasing to longer, sustained ones. Your ability or inability to show interest in, initially watch, then play alongside, and eventually interact with similarly aged peers.

(iii) *Preschool children (age 3 to attainment of age 6).* Children in this age group are evaluated in terms of five areas of development. The following are general descriptions of development typical of this age group.

(A) *Cognitive/communicative development (age 3 to attainment of age 6):* Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; your ability or inability to retain and recall information, images, events, and procedures during the process of thinking (as in the development of readiness skills for formal learning (e.g., learning letters, shapes, colors) and skills for daily living (e.g., putting toys in proper places)). Your ability or inability to communicate by expressing your needs, feelings, and preferences; by telling, requesting, predicting, and relating information; by describing actions and functions; by providing explanations; by following and giving directions; and by engaging in conversation in a spontaneous, interactive, and increasingly intelligible manner, using increasingly complex vocabulary and grammar.

(B) *Motor development (age 3 to attainment of age 6):* Your ability or inability to move and use your arms and legs in increasingly more intricate and coordinated activity, and your ability or inability to use your hands with increasing coordination to manipulate small objects during play (e.g., drawing, using building blocks, constructing puzzles) and physically related daily activities other than self-care (see Personal area).

(C) *Social development (age 3 to attainment of age 6):* Your ability or inability to initiate social exchanges, to organize and regulate your emotions and behaviors, and to respond to your social environment through appropriate and increasingly complex interactions, such as showing affection, sharing, and helping; your ability to relate to caregivers with increasing independence, to choose your own friends, and to play cooperatively with other children, one-at-a-time or in a group.

(D) *Personal development (age 3 to attainment of age 6):* Your ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., bathing, dressing, maintaining sleep habits, crossing the street with an adult).

(E) *Concentration, persistence, or pace (age 3 to attainment of age 6):* Your ability or inability to engage in an activity, and to sustain the activity for a period of time at a reasonable pace (e.g., playing a simple board game).

(iv) *School-age children (age 6 to attainment of age 12).* Children in this age group are evaluated in terms of five areas of functioning. The following are general descriptions of functioning typical of this age group.

(A) *Cognitive/communicative functioning (age 6 to attainment of age 12):* Your ability or inability to learn, understand, and solve problems through

intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability to retain and recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., reading, class discussions) and in daily living (e.g., telling time, making change). Your ability or inability to comprehend and produce language (e.g., vocabulary, grammar) in order to communicate in social conversation (e.g., to express feelings, meet needs, seek information, describe events, share stories), and in learning situations (e.g., 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, using increasingly complex vocabulary and grammar.

(B) *Motor functioning (age 6 to attainment of age 12):* Your ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self-care (see Personal area).

(C) *Social functioning (age 6 to attainment of age 12):* Your ability or inability to play alone, with another child, and 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 in group situations (e.g., siblings, parents or caregivers, peers, teachers, school classes, neighborhood groups).

(D) *Personal functioning (age 6 to attainment of age 12):* Your ability or inability to help yourself and to cooperate with others in taking care of your personal needs, health, and safety (e.g., eating, dressing, maintaining personal hygiene, following safety precautions).

(E) *Concentration, persistence, or pace (age 6 to attainment of age 12):* Your ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

(v) *Adolescents (age 12 to attainment of age 18).* Children in this age group are evaluated in terms of five areas of functioning. The following are general descriptions of functioning typical of this age group.

(A) *Cognitive/communicative functioning (age 12 to attainment of age 18):* Your ability or inability to learn, understand, and solve problems through intuition, perception, verbal and nonverbal reasoning, and the application of acquired knowledge; the ability or inability to retain and recall information, images, events, and procedures during the process of thinking, as in formal learning situations (e.g., composition, classroom discussion) and in daily living (e.g., using the post office, using public transportation). Your ability or inability to comprehend and produce language (e.g., vocabulary, grammar) in order to communicate in conversation (e.g., to express feelings, meet needs, seek information, describe events, tell stories), and in learning situations (e.g., to obtain and convey information and ideas) both spontaneously and interactively, in all communication environments (e.g., home, classroom, game fields, extra-curricular activities, job), and with all communication partners (e.g., parents, siblings, peers, school classes, teachers, employers).

(B) *Motor functioning (age 12 to attainment of age 18):* Your ability or inability to use fine and gross motor skills in order to engage in the physical activities involved in normal mobility, school work, play, physical education, sports, and other physically related daily activities other than self-care (see Personal area).

(C) *Social functioning (age 12 to attainment of age 18):* Your ability or inability 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.

(D) *Personal functioning (age 12 to attainment of age 18):* Your ability or inability to help yourself in taking care of your personal needs, health, and safety (e.g., dressing, bathing, doing laundry, adhering to medication or therapy regimens).

(E) *Concentration, persistence, or pace (age 12 to attainment of age 18):* Your ability or inability to engage in an activity, and to sustain the activity for a period of time and at a reasonable pace.

(d) *Examples of impairments that are functionally equivalent in severity to a listed impairment.* The following are some examples of impairments and limitations that are functionally equivalent to listings. Findings of equivalence based on the disabling functional limitations of a child's impairment(s) are not limited to the examples in this paragraph (d), because these examples do not describe all possible effects of impairments that might be found to be functionally equivalent in severity 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., 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) 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 personal functioning and marked restriction in motor 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 (including psychological) 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 for the gestational age of the infant.)

(10) In an infant who has not attained age 1 year, and who may be too young to test, any limitations caused by a physical impairment(s) or a combination of physical and mental impairments that causes the same functional limitations in listing 112.12.

(11) Major congenital organ dysfunction 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.

(e) *Responsibility for determining functional equivalence.* In cases where the State agency or other designee of the Commissioner makes the initial or reconsideration disability determination, a State agency medical or psychological consultant or other designee of the Commissioner (see § 416.1016) has the overall responsibility for determining functional equivalence. For cases in the disability hearing process or otherwise decided by a disability hearing officer, the responsibility for determining functional equivalence rests with either the disability hearing officer or, if the disability hearing officer's reconsideration 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 functional equivalence rests with the Administrative Law Judge or Appeals Council.

[62 FR 6424, Feb. 11, 1997; 62 FR 13538, 13733, Mar. 21, 1997]

§ 416.927 Evaluating opinion evidence.

(a) *General.* (1) If you are an adult, you can only be found disabled if you

are unable to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (See §416.905.) If you are a child, you can be found disabled only if you have a medically determinable physical or mental impairment(s) that causes marked and severe functional limitations and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. (See §416.906.) 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 in

paragraphs (d)(2)(i) and (d)(2)(ii) of this section, as well as the factors in paragraphs (d)(3) through (d)(6) 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. For example, the amount of understanding of our disability programs and their evidentiary requirements that an acceptable medical source has, regardless of the source of that understanding, and the extent to which an acceptable medical source is familiar with the other information in your case record are relevant factors that we will consider in deciding the weight to give to a medical opinion.

(e) *Medical source opinions on issues reserved to the Commissioner.* Opinions on some issues, such as the examples that follow, are not medical opinions, as described in paragraph (a)(2) of this section, but are, instead, opinions on issues reserved to the Commissioner because they are administrative findings that are dispositive of a case; *i.e.*, that would direct the determination or decision of disability.

(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 Commissioner.* 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 medical 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 Commissioner.

(3) We will not give any special significance to the source of an opinion on issues reserved to the Commissioner described in paragraphs (e)(1) and (e)(2) of this section.

(f) *Opinions of nonexamining sources.* We consider all evidence from nonexamining sources to be opinion evidence. When we consider the opinions of nonexamining sources, we apply the rules in paragraphs (a) through (e) of this section. In addition, the following rules apply to State agency medical and psychological consultants, other program physicians and psychologists, and medical experts 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. They will consider opinions of State agency medical or psychological consultants, other program physicians and psychologists, and medical experts as follows:

(i) Administrative law judges are not bound by any findings made by State agency medical or psychological consultants, or other program physicians or psychologists. However, State agency medical and psychological consultants and other program physicians and psychologists are highly qualified physicians and psychologists who are also experts in Social Security disability evaluation. Therefore, administrative law judges must consider findings of State agency medical and psychological consultants or other program physicians or psychologists as opinion evidence, except for the ultimate determination about whether you are disabled. See §416.912(b)(6).

(ii) When an administrative law judge considers findings of a State agency medical or psychological consultant or other program physician or psychologist, the administrative law judge will evaluate the findings using relevant factors in paragraphs (a) through (e) of this section, such as the physician's or psychologist's medical specialty and expertise in our rules, the supporting evidence in the case record, supporting explanations provided by the physician or psychologist, and any other factors relevant to the weighing of the opinions. Unless the treating source's opinion is given controlling weight, the administrative law judge must explain in the decision the weight given to the opinions of a State agency medical or psychological consultant or other program physician or psychologist, as the administrative law judge must do for any opinions from treating sources, nontreating sources, and other nonexamining sources who do not work for us.

(iii) Administrative law judges may also ask for and consider opinions from medical experts on the nature and severity of your impairment(s) and on whether your impairment(s) equals the requirements of any impairment listed in appendix 1 to subpart P of part 404 of this chapter. When administrative law judges consider these opinions, they will evaluate them using the rules in paragraphs (a) through (e) of this section.

(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, as amended at 62 FR 6428, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997; 62 FR 38454, July 18, 1997; 65 FR 11880, Mar. 7, 2000]

EFFECTIVE DATE NOTE: At 65 FR 11880, Mar. 7, 2000, § 416.927 was amended by revising the section heading, the third sentence of paragraph (d)(2), the heading of paragraph (e), paragraph (e)(2), the heading and introductory text of paragraph (f) and paragraph (f)(2), by adding a sentence to the end of paragraph (d)(6), by adding introductory text to paragraph (e), and by adding paragraph (e)(3), effective Apr. 6, 2000. For the convenience of the user, the superseded text is set forth as follows:

§ 416.927 Evaluating medical opinions about your impairment(s) or disability.

* * * * *

(d) * * *

(2) * * * 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. * * *

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(e) *Medical source opinions on issues reserved to the Commissioner*— * * *

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(2) *Other opinions on issues reserved to the Commissioner.* 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 Commissioner. 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.

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(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.

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§ 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, your functioning). 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, your functioning). 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, your functioning).

(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 Commissioner) 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, if you are a child, your functioning*—(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 or, if you are a child, your functioning. 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, your functioning) 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 or, if you are a child, your functioning. 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, if you are a child, your functioning).* 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, your functioning), 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, your functioning) 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(c) 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 §416.926(a)(b)(3) in determining whether you have an impairment(s) that causes overall functional limitations that are the same as the disabling limitations 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. (See paragraph (d)(4) of this section.)

(4) *Impact of symptoms (including pain) on residual functional capacity or, if you are a child, on your functioning.* 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, or your residual functional capacity, if you are an adult, or, on your functioning if you are a child. (See §416.945 and §§416.924a through 416.924c.)

[56 FR 57944, Nov. 14, 1991, as amended at 62 FR 6429, Feb. 11, 1997; 62 FR 13538, Mar. 21, 1997; 62 FR 38454, July 18, 1997; 65 FR 16814, Mar. 30, 2000]

§ 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, or, if you are a child, if the treatment can reduce your functional limitations so that they are no longer marked and severe.

(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; 62 FR 6429, Feb. 11, 1997]

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 longstanding 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 Commissioner 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 Commissioner. 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, as amended at 62 FR 38454, July 18, 1997]

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 activity as an employee show that you have engaged in substantial gainful activity if—

For months	Your monthly earnings averaged more than
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980—1989	300
In January 1990—June 1999	500
After June 1999	700

(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—

For months	Your monthly earnings averaged less than
In calendar years before 1976	$130
In calendar year 1976	150
In calendar year 1977	160
In calendar year 1978	170
In calendar year 1979	180
In calendar years 1980—1989	190
After December 1989	300

(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—

For months	Your average monthly earnings are not greater than:
In calendar years before 1976	$200
In calendar year 1976	230
In calendar year 1977	240
In calendar year 1978	260
In calendar year 1979	280
In calendar years 1980–1989	300
In January 1990–June 1999	500
After June 1999	700

(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; 64 FR 18570, Apr. 15, 1999; 64 FR 22903, Apr. 28, 1999]

§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]

DISABILITY REDETERMINATIONS FOR INDIVIDUALS WHO ATTAIN AGE 18

§ 416.987 Disability redeterminations for individuals who attain age 18.

(a)(1) Public Law 104–193, *The Personal Responsibility and Work Opportunity Reconciliation Act of 1996,* requires that the individuals described in paragraph (b) of this section must have their eligibility redetermined.

(2) For these individuals, subject to the provisions of paragraphs (b)(2) and (b)(3) of this section, we will use the rules for new applicants; we will not use the rules for determining whether disability continues set out in § 416.994. If you are an individual affected by the provisions of this section, we may find that you are not now disabled even though we previously found that you were disabled.

(3) Before we begin your disability redetermination, we will notify you that we are redetermining your eligibility for payments, why we are redetermining your eligibility, which disability rules we will apply, that our review could result in a finding that your SSI payments based on disability could be terminated, that you have the right to submit medical and other evidence for our consideration during the redetermination, and that when we make our determination, we will notify you of our determination, your right to appeal the determination, and your right to request continuation of benefits during appeal.

(4) We will notify you in writing of the results of the disability redetermination. The notice will tell you what our determination is, the reasons for our determination and your right to request reconsideration of the determination. If our determination shows that we should stop your SSI payments based on disability, the notice will also tell you of your right to request that your benefits continue during any appeal. The results of an initial disability redetermination are binding unless you request a reconsideration within the stated time period, or we revise the initial determination.

(b)(1) We will redetermine the eligibility of individuals

(i) Who became eligible for SSI benefits by reason of disability prior to attaining age 18, and

(ii) Who also were eligible for such benefits for the month before the month in which they attained age 18.

(2) When we make this determination, we will apply the rules in §§ 416.920(c)–(f); we will not apply the rules in § 416.920(b) or § 416.994.

(3) If you are an individual affected by the provisions of this section, and you are disabled under § 416.920 (d) or (f), and you are working, we will apply the rules in §§ 416.260 ff.

(4) We will initiate this disability redetermination during the 1-year period beginning on your 18th birthday.

(5) If we find that you are not disabled under the rules in § 416.920 (except § 416.920(b)), your eligibility will end. The month in which we will find you not disabled is explained in paragraph (b)(6) of this section; the month your benefits will stop is explained in paragraph (b)(7) of this section.

(6) If the evidence shows that you are not disabled, we will find that your disability ended in the earliest of:

(i) The month the evidence shows that you are not disabled under the rules set out in this section, but not earlier than the month in which we mail you a notice saying that you are not disabled.

(ii) The first month in which you failed without good cause to follow prescribed treatment under the rules in § 416.930.

(iii) The first month in which you failed without good cause to do what

we asked. Section 416.1411 explains the factors we will 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.

[62 FR 6429, Feb. 11, 1997]

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 whether your disability or blindness continues;

(10) You have been scheduled for a vocational reexamination diary review; or

(11) By your first birthday, if you are a child whose low birth weight was a contributing factor material to our determination that you were disabled; i.e., whether we would have found you disabled if we had not considered your low birth weight.

(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 or, if you are a child, unlikely to improve to the point that you will no longer have marked and severe functional limitations. 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, as amended at 62 FR 6430, Feb. 11, 1997]

§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 §§ 416.987 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, as amended at 65 FR 16815, Mar. 30, 2000]

§ 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, and whether you are and have been receiving treatment that is medically necessary and available, 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) We will first consider whether there has been medical improvement in your impairment(s). We define ''medical improvement'' in paragraph (c) of this section. If there has been no medical improvement, we will find you are still disabled unless one of the exceptions in paragraphs (e) or (f) of this section applies. If there has been medical improvement, we will consider whether the impairments(s) you had at the time of our most recent favorable determination or decision now meets or medically or functionally equals the severity of the listing it met or equalled at that time. If so, we will find you are still disabled, unless one of the exceptions in paragraphs (e) or (f) of this section applies. If not, we will consider whether your current impairment(s) are disabling under the rules in §416.924. These steps are described in more detail in paragraph (b) of this section. Even where medical improvement 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 ensure 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. However, we may skip steps in the sequence if it is clear this would lead to a more prompt finding that your disability continues. For example, we might not consider the issue of medical improvement if it is obvious on the face of the evidence that a current impairment meets the severity of a listed impairment. If we can make a favorable determination or decision at any point in the sequence, we do not review further. The steps are:

(1) *Has there been medical improvement in your condition(s)?* We will determine whether there has been medical improvement in the impairment(s) you had at the time of our most recent favorable determination or decision. (The term medical improvement is defined in paragraph (c) of this section.) If there has been no medical improvement, we will find that your disability continues, unless one of the exceptions to medical improvement described in paragraph (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(2) *Does your impairment(s) still meet or equal the severity of the listed impairment that it met or equaled before?* If there has been medical improvement, we will consider whether the impairment(s) that we considered at the time of our most recent favorable determination or decision still meets or equals the severity of the listed impairment it met or equaled at that time. In making this decision, we will consider the current severity of the impairment(s) present and documented at the time of our most recent favorable determination or decision, and the same listing section used to make that determination or decision as it was written at that time, even if it has since been revised or removed from the Listing of Impairments. If that impairment(s) does not still meet or equal the severity of that listed impairment, we will proceed to the next step. If that impairment(s) still meets or equals the severity of that listed impairment as it was written at that time, we will find that you are still disabled, unless one of the exceptions to medical improvement described in paragraphs (e) or (f) of this section applies.

(i) If one of the first group of exceptions to medical improvement applies, we will proceed to step 3.

(ii) If one of the second group of exceptions to medical improvement applies, we may find that your disability has ended.

(3) *Are you currently disabled?* If there has been medical improvement in the impairment(s) that we considered at the time of our most recent favorable determination or decision, and if that impairment(s) no longer meets or equals the severity of the listed impairment that it met or equaled at that time, we will consider whether you are disabled under the rules in §§ 416.924(c) and (d). In determining whether you are currently disabled, we will consider all impairments you now have, including any you did not have at the time of our most recent favorable determination or decision, or that we did not

consider at that time. The steps in determining current disability are summarized as follows:

(i) *Do you have a severe impairment or combination of impairment?* If there has been medical improvement in your impairment(s), 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(c). If your impairment(s) is not severe, we will find that your disability has ended. If your impairment(s) is severe, we will then consider whether it meets or medically equals the severity of a listed impairment.

(ii) *Does your impairment(s) meet or medically equal the severity of any impairment listed in appendix 1 of subpart P of part 404 of this chapter?* If your current impairment(s) meets or medically equals the severity of any listed impairment, as described in §§416.925 and 416.926, we will find that your disability continues. If not, we will consider whether it functionally equals the severity of a listed impairment.

(iii) *Does your impairment(s) functionally equal the severity of any listed impairment?* If your current impairment(s) functionally equals the severity of any listed impairment, as described in §416.926a, we will find that your disability continues. If not, we will find that your disability has ended.

(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. Although the decrease in severity may be of any quantity or degree, we will disregard minor changes in your signs, symptoms, and laboratory findings that obviously do not represent medical improvement and could not result in a finding that your disability has ended. 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.

(d) *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 (f) 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 determination or decision (e.g., school records, medical evidence from treating sources, and the results of consultative examination). 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.

(e) *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) no longer results in marked and severe functional limitations. These exceptions to medical improvement are intended to provide a way of finding that a person is no longer disabled in those 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) does not now result in marked and severe functional limitations, 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 determination or decision. The evidence we gather will serve as the basis for the finding that an exception applies.

(1) *Substantial evidence shows that, based on new or improved diagnostic techniques or evaluations, 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 techniques or evaluations 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 impairment 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 meets or equals the severity of any listed impairment, and therefore results in marked and severe functional limitations. 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.

(2) *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.

(f) *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 or that you are currently not disabled under the rules in §416.924. 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 improve your impairment(s) so that it no longer results in marked and severe functional limitations.* If treatment has been prescribed for you which would be expected to improve your impairment(s) so that it no longer results in marked and severe functional limitations, 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.

(g) *The month in which we will find you are no longer disabled.* If the evidence shows that you are no longer disabled, we will find that your disability ended in the 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 (f)(4) of this section applies;

(5) The first month in which you were told by your physician that you could return to normal 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 (f)(2) of this section applies.

(h) *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.

(i) *Requirement for treatment that is medically necessary and available.* If you have a representative payee, the representative payee must, at the time of the continuing disability review, present evidence demonstrating that you are and have been receiving treatment, to the extent considered medically necessary and available, for the condition(s) that was the basis for providing you with SSI benefits, unless we determine that requiring your representative payee to provide such evidence would be inappropriate or unnecessary considering the nature of your impairment(s). If your representative payee refuses without good cause to comply with this requirement, and if we decide that it is in your best interests, we may pay your benefits to another representative payee or to you directly.

(1) *What we mean by treatment that is medically necessary.* Treatment that is medically necessary means treatment that is expected to improve or restore your functioning and that was prescribed by a treating source, as defined in § 416.902. If you do not have a treating source, we will decide whether there is treatment that is medically necessary that could have been prescribed by a treating source. The treatment may include (but is not limited to)—

(i) Medical management;

(ii) Psychiatric, psychological, or psychosocial counseling;

(iii) Physical therapy; and

(iv) Home therapy, such as administering oxygen or giving injections.

(2) *How we will consider whether medically necessary treatment is available.* When we decide whether medically necessary treatment is available, we will consider such things as (but not limited)—

(i) The location of an institution or facility or place where treatment, services, or resources could be provided to

you in relationship to where you reside;

(ii) The availability and cost of transportation for you and your payee to the place of treatment;

(iii) Your general health, including your ability to travel for the treatment;

(iv) The capacity of an institution or facility to accept you for appropriate treatment;

(v) The cost of any necessary medications or treatments that are not paid for by Medicaid or another insurer or source; and

(vi) The availability of local community resources (e.g., clinics, charitable organizations, public assistance agencies) that would provide free treatment or funds to cover treatment.

(3) *When we will not require evidence of treatment that is medically necessary and available.* We will not require your representative payee to present evidence that you are and have been receiving treatment if we find that the condition(s) that was the basis for providing you benefits is not amenable to treatment.

(4) *Removal of a payee who does not provide evidence that a child is and has been receiving treatment that is medically necessary and available.* If your representative payee refuses without good cause to provide evidence that you are and have been receiving treatment that is medically necessary and available, we may, if it is in your best interests, suspend payment of benefits to the representative payee, and pay benefits to another payee or to you. When we decide whether your representative payee had good cause, we will consider factors such as the acceptable reasons for failure to follow prescribed treatment in §416.930(c) and other factors similar to those describing good cause for missing deadlines in §416.1411.

(5) *If you do not have a representative payee.* If you do not have a representative payee and we make your payments directly to you, the provisions of this paragraph do not apply to you. However, we may still decide that you are failing to follow prescribed treatment under the provisions of §416.930, if the requirements of that section are met.

[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; 62 FR 6430, Feb. 11, 1997; 62 FR 13538, 13733, Mar. 21, 1997; 65 FR 16815, Mar. 30, 2000]

§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, or, if you are a child, to result in marked and severe functional limitations.

[62 FR 6432, Feb. 11, 1997]

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 Commissioner under title XVI of the Act. It also establishes the Commissioner'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 Commissioner and the States covered in detail in other sections.

(b) Sections 416.1010 through 416.1018 describe the Commissioner'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 Commissioner 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 Commissioner will provide State agencies to help them improve performance.

(f) Sections 416.1070 through 416.1075 describe the level of performance below which the Commissioner 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 Commissioner 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 Commissioner will take and what action the State will be expected to take if the Commissioner assumes the disability determination function from a State agency.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38454, July 18, 1997]

§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.

Commissioner means the Commissioner of Social Security or his or her authorized designee.

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 and Policy, 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.

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).

[46 FR 29211, May 29, 1981, as amended at 56 FR 11021, Mar. 14, 1991; 62 FR 38454, July 18, 1997]

§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 Commissioner, 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.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§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 Commissioner 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; 62 FR 38455, July 18, 1997]

§ 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 Commissioner of Social Security 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, as amended at 62 FR 38455, July 18, 1997]

§ 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 Social Security Administration 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

[1] The circular is available from the Office of Administration, Publications Unit, Rm. G–236, New Executive Office Bldg., Washington, DC 20503.

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; 62 FR 38455, July 18, 1997]

§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 Commissioner*—(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 SSA's Inspector General or audited or reviewed by SSA as appropriate. These audits or reviews will be conducted to determine whether the expenditures were made for the intended purposes and in amounts necessary for the proper and efficient administration of the disability programs. Audits or reviews will also be made to inspect the work and activities required by the regulations to ensure compliance with pertinent Federal statutes and regulations. The State will make every effort to act upon and resolve any items questioned in an audit or review.

(2) *Questioned items.* Expenditures of State agencies will be audited or reviewed, as appropriate, on the basis of cost principles and written guidelines in effect at the time the expenditures were made or incurred. Both the State and the State agency will be informed and given a full explanation of any items questioned. They will be given reasonable time to explain items questioned. Any explanation furnished by the State or State agency will be given full consideration before a final determination is made on the audit or review report.

(3) *State appeal of audit determinations.* The appropriate Social Security Administration Regional Commissioner will notify the State of his or her determination on the audit or review report. If the State disagrees with that determination, the State may request reconsideration in writing within 60 days of the date of the Regional Commissioner's notice of the determination. The written request may be made, through the Associate Commissioner, Office of Disability, to the Commissioner of Social Security, Room 900, Altmeyer Building, 6401 Security Boulevard, Baltimore, 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, as amended at 62 FR 38455, July 18, 1997]

§ 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 Commissioner'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; 62 FR 38455, July 18, 1997]

§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 Department of Health and Human Services' Departmental Appeals Board (the Board).

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§ 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 Commissioner.* 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.

[46 FR 29211, May 29, 1981, as amended at 62 FR 38455, July 18, 1997]

§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 416.1148 of this part. 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.

[45 FR 65547, Oct. 3, 1980, as amended at 65 FR 16815, Mar. 30, 2000]

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) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;

(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 separate 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 the 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;

(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;

(19) Hostile fire pay received from one of the uniformed services pursuant to 37 U.S.C. 310; and

(20) Interest or other earnings on a dedicated account which is excluded from resources. (See §416.1247).

[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; 61 FR 49964, Sept. 24, 1996; 61 FR 67207, Dec. 20, 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) we use the in-kind support and maintenance you receive in the month as described in §416.420 to determine your SSI benefit. We value the in-kind support and maintenance using the Federal benefit rate for the month in which you receive it. *Exception:* For the first 2 months for which a cost-of-living adjustment applies, we value in-kind support and maintenance you receive using the VTR or PMV based on the Federal benefit rate as increased by the cost-of-living adjustment.

Example: Mr. Jones 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 because he lives in the household of a son who provides both food and shelter (in-kind support and maintenance). In January, we increase his SSI benefit because of a cost-of-living adjustment. We base his SSI payment for that month on the food and shelter he received from his son two months earlier in November. In determining the value of that food and shelter he received in November, we use the Federal benefit rate for January.

(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; 63 FR 33546, June 19, 1998]

§ 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]

§ 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 you otherwise would be subject to the reduced benefit rate described in §416.414, and you 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 where you are eligible for the reduced benefits payable under §416.414 for full months in the facility, 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, 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; 62 FR 1056, Jan. 8, 1997]

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) We use the income from the first month you are initially eligible for payment of SSI benefits (see § 416.501) to determine your benefit amount for that month. In the following month (the second month you are eligible for payment), we use the same countable income that we used in the preceding month to determine your benefit amount.

(ii) To determine your benefit amount for the first month you again become eligible after you have been ineligible for at least a month, we use the same countable income that we use to determine your eligibility for that month. In the following month (the second month of reeligibility), we use the same countable income that we used in the preceding month to determine your benefit amount.

(iii) 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)).

(iv) 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; 64 FR 31974, June 15, 1999]

§ 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) Alaska Longevity Bonus payments made to an individual who is a resident of Alaska and who, prior to October 1, 1985: met the 25-year residency requirement for receipt of such payments in effect prior to January 1, 1983; and was eligible for SSI;

(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));

(22) Relocation assistance, as described in § 416.1124(c)(18); and

(23) Hostile fire pay received from one of the uniformed services pursuant to 37 U.S.C. 310;

(24) Impairment-related work expenses, as described in 20 CFR 404.1576, incurred and paid by an ineligible spouse or parent, if the ineligible spouse or parent receives disability benefits under title II of the Act; and

(25) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which are left to accumulate and become part of separate burial funds, and interest accrued on and left to accumulate as part of the value of agreements representing the purchase of excluded burial spaces (see § 416.1124(c) (9) and (15)).

(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; 61 FR 49964, Sept. 24, 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 payment of an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility for payment (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; 64 FR 31974, June 15, 1999]

§ 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 payment of an SSI benefit or if you are again eligible after at least a month of being ineligible). In the first month of your eligibility for payment (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, as described in §416.414;

(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; 62 FR 1056, Jan. 8, 1997; 64 FR 31974, June 15, 1999]

§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 paragraph (e) of this section 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(e).

(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; 64 FR 31975, June 15, 1999]

§ 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.

(c) *Active duty military service.* If your ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the Armed Forces on active duty, we continue to consider that person to be living in the same household as you, absent evidence to the contrary. If we determine that during such an absence, evidence indicates that your spouse or parent should no longer be considered to be living in the same household as you, then deeming will cease. When such evidence exists, we determine the month in which your spouse or parent should no longer be considered to be living in the same household as you and stop deeming his or her income and resources beginning with the month following that month.

Example: Tom is a child who receives SSI. In January 1996, Tom's father leaves the household due solely to an active duty assignment as a member of the Armed Forces. Five months later in June 1996, while Tom's father is still on an active duty assignment, Tom's parents file for divorce. As a result, Tom's father will not be returning to live in Tom's household. Therefore, Tom's father should no longer be considered to be living in the same household with Tom. Beginning July 1, 1996, deeming from Tom's father will cease.

[50 FR 48579, Nov. 26, 1985, as amended at 61 FR 10280, Mar. 13, 1996; 62 FR 42411, Aug. 7, 1997]

§ 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 or 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; 62 FR 59813, Nov. 5, 1997]

§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) *Types of Payments Excluded Without Regard to Specific Tribes or Groups—*

(1) 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 section 4 of Public Law 97–458 (96 Stat. 2513, 25 U.S.C. 1408). 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.

(2) 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 (97 Stat. 365, 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)(3) of this appendix.

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(3) 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 (101 Stat. 1812, 43 U.S.C. 1626(c)), effective February 3, 1988.

NOTE: This exclusion does not apply in deeming income from sponsors to aliens.

(4) Up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands under section 13736 of Public Law 103–66 (107 Stat. 663, 25 U.S.C. 1408, as amended).

(b) *Payments to Members of Specific Indian Tribes and Groups—*

(1) Per capita payments to members of the Red Lake Band of Chippewa Indians from the proceeds of the sale of timber and lumber on the Red Lake Reservation under section 3 of Public Law 85–794 (72 Stat. 958).

(2) Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members which resulted from judgment funds to the tribes under section 4 of Public Law 92–254 (86 Stat. 65) and under section 6 of Public Law 97–408 (96 Stat. 2036).

(3) Settlement fund payments and the availability of such funds to members of the Hopi and Navajo Tribes under section 22 of Public Law 93–531 (88 Stat. 1722) as amended by Public Law 96–305 (94 Stat. 929).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(4) Judgment funds distributed per capita to, or held in trust for, members of the Sac and Fox Indian Nation, and the availability

of such funds under section 6 of Public Law 94–189 (89 Stat. 1094).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(5) Judgment funds distributed per capita to, or held in trust for, members of the Grand River Band of Ottawa Indians, and the availability of such funds under section 6 of Public Law 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.

(6) Any judgment funds distributed per capita to members of the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation under section 2 of Public Law 95–433 (92 Stat. 1047, 25 U.S.C. 609c–1).

(7) Any judgment funds distributed per capita or made available for programs for members of the Delaware Tribe of Indians and the absentee Delaware Tribe of Western Oklahoma under section 8 of Public Law 96–318 (94 Stat. 971).

(8) All funds and distributions to members of the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians under the Maine Indian Claims Settlement Act, and the availability of such funds under section 9 of Public Law 96–420 (94 Stat. 1795, 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.

(9) Any distributions of judgment funds to members of the San Carlos Apache Indian Tribe of Arizona under section 7 of Public Law 93–134 (87 Stat. 468) and Public Law 97–95 (95 Stat. 1206).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(10) Any distribution of judgment funds to members of the Wyandot Tribe of Indians of Oklahoma under section 6 of Public Law 97–371 (96 Stat. 1814).

(11) Distributions of judgment funds to members of the Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma and the Cherokee Band of Shawnee descendants) under section 7 of Public Law 97–372 (96 Stat. 1816).

(12) Judgment funds distributed per capita or made available for programs for members of the Miami Tribe of Oklahoma and the Miami Indians of Indiana under section 7 of Public Law 97–376 (96 Stat. 1829).

(13) Distributions of judgment funds to members of the Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community and the Jamestown Band of Clallam Indians) under section 6 of Public Law 97–402 (96 Stat. 2021).

(14) Judgment funds distributed per capita or made available for programs for members of the Pembina Chippewa Indians (Turtle Mountain Band of Chippewa Indians, Chippewa Cree Tribe of Rocky Boy's Reservation, Minnesota Chippewa Tribe, Little Shell Band of the Chippewa Indians of Montana, and the nonmember Pembina descendants) under section 9 of Public Law 97–403 (96 Stat. 2025).

(15) Per capita distributions of judgment funds to members of the Assiniboine Tribe of Fort Belknap Indian Community and the Papago Tribe of Arizona under sections 6 and 8(d) of Public Law 97–408 (96 Stat. 2036, 2038).

(16) Up to $2,000 of per capita distributions of judgment funds to members of the Confederated Tribes of the Warm Springs Reservation under section 4 of Public Law 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.

(17) Judgment funds distributed to the Red Lake Band of Chippewa Indians under section 3 of Public Law 98–123 (97 Stat. 816).

(18) Funds distributed per capita or family interest payments for members of the Assiniboine Tribe of Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana under section 5 of Public Law 98–124 (97 Stat. 818).

(19) Distributions of judgment funds and income derived therefrom to members of the Shoalwater Bay Indian Tribe under section 5 of Public Law 98–432 (98 Stat. 1672).

(20) All distributions to heirs of certain deceased Indians under section 8 of the Old Age Assistance Claims Settlement Act, Public Law 98–500 (98 Stat. 2319).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(21) Judgment funds distributed per capita or made available for any tribal program for members of the Wyandotte Tribe of Oklahoma and the Absentee Wyandottes under section 106 of Public Law 98–602 (98 Stat. 3151).

(22) Per capita and dividend payment distributions of judgment funds to members of the Santee Sioux Tribe of Nebraska, the Flandreau Santee Sioux Tribe, the Prairie Island Sioux, Lower Sioux, and Shakopee Mdewakanton Sioux Communities of Minnesota under section 8 of Public Law 99–130 (99 Stat. 552) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

(23) Funds distributed per capita or held in trust for members of the Chippewas of Lake

Superior and the Chippewas of the Mississippi under section 6 of Public Law 99–146 (99 Stat. 782).

(24) Distributions of claims settlement funds to members of the White Earth Band of Chippewa Indians as allottees, or their heirs, under section 16 of Public Law 99–264 (100 Stat. 70).

(25) Payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the Saginaw Chippewa Indian Tribe of Michigan under section 6 of Public Law 99–346 (100 Stat. 677).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(26) Judgment funds distributed per capita or held in trust for members of the Chippewas of Lake Superior and the Chippewas of the Mississippi under section 4 of Public Law 99–377 (100 Stat. 805).

(27) Judgment funds distributed to members of the Cow Creek Band of Umpqua Tribe of Indians under section 4 of Public Law 100–139 (101 Stat. 822).

(28) Per capita payments of claims settlement funds to members of the Coushatta Tribe of Louisiana under section 2 of Public Law 100–411 (102 Stat. 1097) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(29) Funds distributed per capita for members of the Hoopa Valley Indian Tribe and the Yurok Indian Tribe under sections 4, 6 and 7 of Public Law 100–580 (102 Stat. 2929, 2930, 2931) and section 3 of Public Law 98–64 (97 Stat. 365; 25 U.S.C. 117b).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(30) Judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the Wisconsin Band of Potawatomi (Hannahville Indian Community and Forest County Potawatomi) under section 503 of Public Law 100–581 (102 Stat. 2945).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(31) All funds, assets, and income from the trust fund transferred to the members of the Puyallup Tribe under section 10 of the Puyallup Tribe of Indians Settlement Act of 1989, Public Law 101–41 (103 Stat. 88, 25 U.S.C. 1773h(c)).

NOTE: This exclusion does not apply in deeming income from sponsors to aliens.

(32) Judgment funds distributed per capita, or held in trust, or made available for programs, for members of the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida under section 8 of Public Law 101–277 (104 Stat. 145).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(33) Payments, funds, distributions, or income derived from them to members of the Seneca Nation of New York 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.

(34) Per capita distributions of settlement funds under section 102 of the Fallon Paiute Shoshone Indian Tribes Water Rights Settlement Act of 1990, Public Law 101–618 (104 Stat. 3289) and section 7 of Public Law 93–134 (87 Stat. 468), as amended by Public Law 97–458 (96 Stat. 2513; 25 U.S.C. 1407).

(35) Settlement funds, assets, income, payments, or distributions from Trust Funds to members of the Catawba Indian Tribe of South Carolina under section 11(m) of Public Law 103–116 (107 Stat. 1133).

(36) Settlement funds held in trust (including interest and investment income accruing on such funds) for, and payments made to, members of the Confederated Tribes of the Colville Reservation under section 7(b) of Public Law 103–436 (108 Stat. 4579).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(c) *Receipts from Lands Held in Trust for Certain Tribes or Groups*—

(1) Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Public Law 94–114 (89 Stat. 579, 25 U.S.C. 459e).

NOTE: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

(2) Receipts derived from trust lands awarded to the Pueblo of Santa Ana and distributed to members of that tribe under section 6 of Public Law 95–498 (92 Stat. 1677).

(3) Receipts derived from trust lands awarded to the Pueblo of Zia of New Mexico and distributed to members of that tribe under section 6 of Public Law 95–499 (92 Stat. 1680).

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).

(f) The value of any child care provided or arranged (or any payment for such care or reimbursement for costs incurred for such care) under the Child Care and Development Block Grant Act, as amended by section 8(b) of Public Law 102–586 (106 Stat. 5035).

(g) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103–286 (108 Stat. 1450).

[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; 62 FR 30982, June 6, 1997]

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 §§416.1802 through 416.1835 of this part, 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, as described in § 416.414;

(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; 62 FR 1056, Jan. 8, 1997; 65 FR 16815, Mar. 30, 2000]

§ 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;

(q) Relocation assistance from a State or local government as provided in §416.1239; and

(r) Dedicated financial institution accounts as provided in §416.1247.

[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; 61 FR 67207, Dec. 20, 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) Payments made to Native Americans as listed in paragraphs (b) and (c) of section IV of the appendix to subpart K of part 416, as provided by Federal statutes other than the Social Security Act.

(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 the treatment of ANRVC dividend distributions, see paragraph (a)(10) of this section.

(13) 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)).

(14) 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.

(15) 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).

(16) 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).

(17) Payments made under section 6 of the Radiation Exposure Compensation Act, Public Law 101–426 (104 Stat. 925, 42 U.S.C. 2210).

(18) Payments made to individuals because of their status as victims of Nazi persecution excluded pursuant to section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103–286 (108 Stat. 1450).

(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; 62 FR 30983, June 6, 1997]

§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 disposal 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 benefits paid during the 9-month disposal period 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-month disposal period has expired.

(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 receiving notice that we have accepted the individual's signed written agreement to dispose of the property, 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 conditional benefits through the expiration of the 9 month disposal period 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 at §§ 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, as amended at 62 FR 30983, June 6, 1997; 64 FR 31975, June 15, 1999]

§ 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]

§416.1247 Exclusion of a dedicated account in a financial institution.

(a) *General.* In determining the resources of an individual (or spouse, if any), the funds in a dedicated account in a financial institution established and maintained in accordance with §416.640(e) will be excluded from resources. This exclusion applies only to benefits which must or may be deposited in such an account, as specified in §416.546, and accrued interest or other earnings on these benefits. If these funds are commingled with any other funds (other than accumulated earnings or interest) this exclusion will not apply to any portion of the funds in the dedicated account.

(b) *Exclusion during a period of suspension or termination*—(1) *Suspension.* The exclusion of funds in a dedicated account and interest and other earnings thereon continues to apply during a period of suspension due to ineligibility as described in §416.1321, administrative suspension, or a period of eligibility for which no payment is due, so long as the individual's eligibility has not been terminated as described in §§416.1331 through 416.1335.

(2) *Termination.* Once an individual's eligibility has been terminated, any funds previously excluded under paragraph (a) of this section may not be excluded if the individual establishes a subsequent period of eligibility by filing a new application.

[61 FR 67207, Dec. 20, 1996]

§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 §§ 416.1100 through 416.1124 of this part) 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; 65 FR 16815, Mar. 30, 2000]

§ 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 from the start of the first month that you are no longer eligible for SSI 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, as amended at 64 FR 31975, June 15, 1999]

§ 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 §416.1413 or §416.1425 of this part, 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 §416.1411 of this part 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, as amended at 65 FR 16815, Mar. 30, 2000]

§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: Secs. 702(a)(5), 1631, and 1633 of the Social Security Act (42 U.S.C. 902(a)(5), 1383, and 1383b); 31 U.S.C. 3720A.

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);

(16) Termination of Federal administration of State supplementary payments; and

(17) Findings on whether we can collect an overpayment by using the Federal income tax refund offset procedure. (See §416.583).

(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; 62 FR 49440, Sept. 22, 1997]

§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 judgewill 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, 416.927, 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 April 2, 2001.

[60 FR 34132, June 30, 1995, as amended at 63 FR 35516, June 30, 1998; 64 FR 13678, Mar. 22, 1999; 64 FR 51894, Sept. 27, 1999; 65 FR 16815, Mar. 30, 2000]

§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 Commissioner. 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; 62 FR 38455, July 18, 1997]

§ 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

§ 416.1466 Testing elimination of the request for Appeals Council review.

(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 elimination of the request for review by the Appeals Council. These procedures will apply in randomly selected cases in which we have tested a combination of model procedures for modifying the disability claim process as authorized under §§ 416.1406 and 416.1443, and in which an administrative law judge has issued a decision (not including a recommended decision) that is less than wholly favorable to you.

(b) *Effect of an administrative law judge's decision.* In a case to which the procedures of this section apply, the decision of an administrative law judge will be binding on all the parties to the hearing unless—

(1) You or another party file an action concerning the decision in Federal district court;

(2) The Appeals Council decides to review the decision on its own motion under the authority provided in § 416.1469, and it issues a notice announcing its decision to review the case on its own motion no later than the day before the filing date of a civil action establishing the jurisdiction of a Federal district court; or

(3) The decision is revised by the administrative law judge or the Appeals Council under the procedures explained in § 416.1487.

(c) *Notice of the decision of an administrative law judge.* The notice of decision the administrative law judge issues in a case processed under this section will advise you and any other parties to the decision that you may file an action in a Federal district court within 60 days after the date you receive notice of the decision.

(d) *Extension of time to file action in Federal district court.* Any party having a right to file a civil action under this section may request that the time for filing an action in 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. 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 will use the standards in §416.1411.

[62 FR 49603, Sept. 23, 1997]

§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.

(a) *General.* Anytime within 60 days after the date of a decision or dismissal that is subject to review under this section, the Appeals Council may decide on its own motion to review the action that was taken in your case. We may refer your case to the Appeals Council for it to consider reviewing under this authority.

(b) *Identification of cases.* We will identify a case for referral to the Appeals Council for possible review under its own-motion authority before we effectuate a decision in the case. We will identify cases for referral to the Appeals Council through random and selective sampling techniques, which we may use in association with examination of the cases identified by sampling. We will also identify cases for referral to the Appeals Council through the evaluation of cases we conduct in order to effectuate decisions.

(1) *Random and selective sampling and case examinations.* We may use random and selective sampling to identify cases involving any type of action (i.e., wholly or partially favorable decisions, unfavorable decisions, or dismissals) and any type of benefits (i.e., benefits based on disability and benefits not based on disability). We will use selective sampling to identify cases that exhibit problematic issues or fact patterns that increase the likelihood of error. Neither our random sampling procedures nor our selective sampling procedures will identify cases based on the identity of the decisionmaker or the identity of the office issuing the decision. We may examine cases that have been identified through random or selective sampling to refine the identification of cases that may meet the criteria for review by the Appeals Council.

(2) *Identification as a result of the effectuation process.* We may refer a case requiring effectuation to the Appeals Council if, in the view of the effectuating component, the decision cannot be effectuated because it contains a clerical error affecting the outcome of the claim; the decision is clearly inconsistent with the Social Security Act, the regulations, or a published ruling; or the decision is unclear regarding a

matter that affects the claim's outcome.

(c) *Referral of cases.* We will make referrals that occur as the result of a case examination or the effectuation process in writing. The written referral based on the results of such a case examination or the effectuation process will state the referring component's reasons for believing that the Appeals Council should review the case on its own motion. Referrals that result from selective sampling without a case examination may be accompanied by a written statement identifying the issue(s) or fact pattern that caused the referral. Referrals that result from random sampling without a case examination will only identify the case as a random sample case.

(d) *Appeals Council's action.* If the Appeals Council decides to review a decision or dismissal on its own motion, it will mail a notice of review to all the parties as provided in § 416.1473. The Appeals Council will include with that notice a copy of any written referral it has received under paragraph (c) of this section. The Appeals Council's decision to review a case is established by its issuance of the notice of review. If it is unable to decide within the applicable 60-day period whether to review a decision or dismissal, the Appeals Council may consider the case to determine if the decision or dismissal should be reopened pursuant to §§ 416.1487 and 416.1488. If the Appeals Council decides to review a decision on its own motion or to reopen a decision as provided in §§ 416.1487 and 416.1488, the notice of review or the notice of reopening issued by the Appeals Council will advise, where appropriate, that interim benefits will be payable if a final decision has not been issued within 110 days after the date of the decision that is reviewed or reopened, and that any interim benefits paid will not be considered overpayments unless the benefits are fraudulently obtained.

[63 FR 36571, July 7, 1998]

§ 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 Commissioner for further consideration, the Appeals Council, acting on behalf of the Commissioner, 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, as amended at 62 FR 38455, July 18, 1997]

§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 Commissioner 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 Commissioner 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 Commissioner 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 Commissioner 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 Commissioner 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 Commissioner after remand.

[54 FR 37793, Sept. 13, 1989, as amended at 62 FR 38455, July 18, 1997]

§ 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) *General.* We will apply a holding in a United States Court of Appeals decision that we determine conflicts with our interpretation of a provision of the Social Security Act or regulations unless the Government seeks further judicial 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 the administrative review process within the applicable circuit unless the holding, by its nature, applies only at certain levels of adjudication.

(b) *Issuance of an Acquiescence Ruling.* 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 judicial review or is unsuccessful on further review, we will issue a Social Security Acquiescence Ruling. The Acquiescence Ruling will describe the administrative case and the court decision, identify the issue(s) involved, and explain how we will apply the holding, including, as necessary, how the holding relates to other decisions within the applicable circuit. These Acquiescence Rulings will generally be effective on the date of their publication in the FEDERAL REGISTER and will apply to all determinations, redeterminations, and decisions made on or after that date unless an Acquiescence Ruling is rescinded as stated in paragraph (e) of this section. The process we will use when issuing an Acquiescence Ruling follows:

(1) We will release an Acquiescence Ruling for publication in the FEDERAL REGISTER for any precedential circuit court decision that we determine contains a holding that conflicts with our interpretation of a provision of the Social Security Act or regulations no later than 120 days from the receipt of the court's decision. This timeframe will not apply when we decide to seek further judicial review of the circuit court decision or when coordination with the Department of Justice and/or other Federal agencies makes this timeframe no longer feasible.

(2) If we make a determination or decision on your claim between the date of a circuit court decision and the date we publish an Acquiescence Ruling, you may request application of the published Acquiescence Ruling to the prior determination or decision. You must demonstrate that application of the Acquiescence Ruling could change the prior determination or decision in your case. You may demonstrate this by submitting a statement that cites the Acquiescence Ruling or the holding or portion of a circuit court decision which could change the prior determination or decision in your case. If you can so demonstrate, we will readjudicate the claim in accordance with the Acquiescence Ruling at the level at which it was last adjudicated. Any readjudication will be limited to

consideration of the issue(s) covered by the Acquiescence 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 you file a request for readjudication within the 60-day appeal period and we deny that request, we shall extend the time to file an appeal on the merits of the claim to 60 days after the date that we deny the request for readjudication.

(3) After we receive a precedential circuit court decision and determine that an Acquiescence Ruling may be required, we will begin to identify those claims that are pending before us within the circuit and that might be subject to readjudication if an Acquiescence Ruling is subsequently issued. When an Acquiescence Ruling is published, we will send a notice to those individuals whose cases we have identified which may be affected by the Acquiescence Ruling. The notice will provide information about the Acquiescence Ruling and the right to request readjudication under that Acquiescence Ruling, as described in paragraph (b)(2) of this section. It is not necessary for an individual to receive a notice in order to request application of an Acquiescence Ruling to his or her claim, as described in paragraph (b)(2) of this section.

(c) *Relitigation of court's holding after publication of an Acquiescence Ruling.* After we have published an 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 may 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 circuit court decision 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 an Acquiescence Ruling.

(2) The General Counsel of the Social Security Administration, 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 to selected claims in the administrative review process 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 within the circuit to claims in the administrative review process selected for relitigation. The notice will explain why we made this decision.

(d) *Notice of relitigation.* 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, decision-makers 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) *Rescission of an Acquiescence Ruling.* We will rescind as obsolete an Acquiescence Ruling and apply our interpretation of the Social Security Act or regulations by publishing a notice in the FEDERAL REGISTER when any of the following events occurs:

(1) The Supreme Court overrules or limits a circuit court holding that was the basis of an Acquiescence Ruling;

(2) A circuit court overrules or limits itself on an issue that was the basis of an Acquiescence Ruling;

(3) A Federal law is enacted that removes the basis for the holding in a decision of a circuit court that was the subject of an Acquiescence Ruling; or

(4) We subsequently clarify, modify or revoke the regulation or ruling that was the subject of a 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.

[63 FR 24933, May 6, 1998]

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 at 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 (SSA).

You or *your* refers to any person or the eligible spouse of any person claiming or receiving supplemental security income benefits.

[45 FR 52106, Aug. 5, 1980, as amended at 62 FR 38455, July 18, 1997]

§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 SSA 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.

[45 FR 52106, Aug. 5, 1980, as amended at 62 FR 38455, July 18, 1997]

§416.1540 Rules of conduct and standards of responsibility for representatives.

(a) *Purpose and scope.* (1) All attorneys or other persons acting on behalf of a party seeking a statutory right or benefit shall, in their dealings with us, faithfully execute their duties as agents and fiduciaries of a party. A representative shall provide competent assistance to the claimant and recognize the authority of the Agency to lawfully administer the process. The following provisions set forth certain affirmative duties and prohibited actions which shall govern the relationship between the representative and the Agency, including matters involving our administrative procedures and fee collections.

(2) All representatives shall be forthright in their dealings with us and with the claimant and shall comport themselves with due regard for the nonadversarial nature of the proceedings by complying with our rules and standards, which are intended to ensure orderly and fair presentation of evidence and argument.

(b) *Affirmative duties.* A representative shall, in conformity with the regulations setting forth our existing duties and responsibilities and those of claimants (see §416.912 in disability and blindness claims):

(1) Act with reasonable promptness to obtain the information and evidence that the claimant wants to submit in support of his or her claim, and forward the same to us for consideration as soon as practicable. In disability and blindness claims, this includes the obligations to assist the claimant in bringing to our attention everything that shows that the claimant is disabled or blind, and to assist the claimant in furnishing medical evidence that the claimant intends to personally provide and other evidence that we can use to reach conclusions about the claimant's medical impairment(s) and, if material to the determination of whether the claimant is blind or disabled, its effect upon the claimant's ability to work on a sustained basis, pursuant to § 416.912(a);

(2) Assist the claimant in complying, as soon as practicable, with our requests for information or evidence at any stage of the administrative decisionmaking process in his or her claim. In disability and blindness claims, this includes the obligation pursuant to § 416.912(c) to assist the claimant in providing, upon our request, evidence about:

(i) The claimant's age;

(ii) The claimant's education and training;

(iii) The claimant's work experience;

(iv) The claimant's daily activities both before and after the date the claimant alleges that he or she became disabled;

(v) The claimant's efforts to work; and

(vi) Any other factors showing how the claimant's impairment(s) affects his or her ability to work, or, if the claimant is a child, his or her functioning. In §§ 416.960 through 416.969, we discuss in more detail the evidence we need when we consider vocational factors; and

(3) Conduct his or her dealings in a manner that furthers the efficient, fair and orderly conduct of the administrative decisionmaking process, including duties to:

(i) Provide competent representation to a claimant. Competent representation requires the knowledge, skill, thoroughness and preparation reasonably necessary for the representation. This includes knowing the significant issue(s) in a claim and having a working knowledge of the applicable provisions of the Social Security Act, as amended, the regulations and the Rulings; and

(ii) Act with reasonable diligence and promptness in representing a claimant. This includes providing prompt and responsive answers to requests from the Agency for information pertinent to processing of the claim.

(c) *Prohibited actions.* A representative shall not:

(1) In any manner or by any means threaten, coerce, intimidate, deceive or knowingly mislead a claimant, or prospective claimant or beneficiary, regarding benefits or other rights under the Act;

(2) Knowingly charge, collect or retain, or make any arrangement to charge, collect or retain, from any source, directly or indirectly, any fee for representational services in violation of applicable law or regulation;

(3) Knowingly make or present, or participate in the making or presentation of, false or misleading oral or written statements, assertions or representations about a material fact or law concerning a matter within our jurisdiction;

(4) Through his or her own actions or omissions, unreasonably delay or cause to be delayed, without good cause (see § 416.1411(b)), the processing of a claim at any stage of the administrative decisionmaking process;

(5) Divulge, without the claimant's consent, except as may be authorized by regulations prescribed by us or as otherwise provided by Federal law, any information we furnish or disclose about a claim or prospective claim;

(6) Attempt to influence, directly or indirectly, the outcome of a decision, determination or other administrative action by offering or granting a loan, gift, entertainment or anything of value to a presiding official, Agency employee or witness who is or may reasonably be expected to be involved in the administrative decisionmaking process, except as reimbursement for legitimately incurred expenses or lawful compensation for the services of an expert witness retained on a non-contingency basis to provide evidence; or

(7) Engage in actions or behavior prejudicial to the fair and orderly conduct of administrative proceedings, including but not limited to:

(i) Repeated absences from or persistent tardiness at scheduled proceedings without good cause (see §416.1411(b));

(ii) Willful behavior which has the effect of improperly disrupting proceedings or obstructing the adjudicative process; and

(iii) Threatening or intimidating language, gestures or actions directed at a presiding official, witness or Agency employee which results in a disruption of the orderly presentation and reception of evidence.

[63 FR 41417, Aug. 4, 1998]

§416.1545 Violations of our requirements, rules, or standards.

When we have evidence that a representative fails to meet our qualification requirements or has violated the rules governing dealings with us, we may begin proceedings to suspend or disqualify that individual from acting in a representational capacity before us. We may file charges seeking such sanctions when we have evidence that a representative:

(a) Does not meet the qualifying requirements described in §416.1505;

(b) Has violated the affirmative duties or engaged in the prohibited actions set forth in §416.1540; or

(c) Has been convicted of a violation under section 1631(d) of the Act.

[63 FR 41418, Aug. 4, 1998]

§416.1550 Notice of charges against a representative.

(a) The Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), 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 Disability and Income Security Programs (or other official the Commissioner may designate), 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; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998]

§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 Disability and Income Security Programs (or other official the Commissioner may designate), 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 Disability and Income Security Programs (or other official the Commissioner may designate), 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 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; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998]

§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 Deputy Commissioner for Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee, upon notification of receipt of the request, shall have 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 Disability and Income Security Programs (or other official the Commissioner may designate), or his or her designee.

(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; 62 FR 38455, July 18, 1997; 63 FR 41418, Aug. 4, 1998]

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 has established an actual dwelling place within the geographical limits of the United States with the intent to continue to live 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.

[47 FR 3106, Jan. 22, 1982, as amended at 62 FR 59813, Nov. 5, 1997]

§ 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, recorded in the United States within 3 months of your birth, 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.

[47 FR 3106, Jan. 22, 1982, as amended at 62 FR 59813, Nov. 5, 1997]

§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 issued by the Immigration and Naturalization Service (INS) in accordance with that Agency's current regulations;

(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; 61 FR 56134, Oct. 31, 1996]

§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 first day of the month following the date the application is filed (for the initial month of eligibility for payment based on that 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 through 416.1835 of this part.

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; 64 FR 31975, June 15, 1999; 65 FR 16815, Mar. 30, 2000]

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 first month for which you are eligible for payment of SSI benefits and ending with, and including, the month your SSI 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 Commissioner 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; 62 FR 38455, July 18, 1997; 64 FR 31975, June 15, 1999]

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 Commissioner 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 benefits.* 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; 62 FR 38455, July 18, 1997]

§ 416.2005 Administration agreements with SSA.

(a) *Agreement-mandatory only.* Subject to the provisions of paragraph (d) of this section, any State having an agreement with the Social Security Administration (SSA) under § 416.2001(c) may enter into an administration agreement with SSA under which SSA 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 SSA under which the State will provide both mandatory and optional State supplementary payments and elect Federal administration of such State supplementary payment programs. If SSA agrees to administer such State's optional supplementary payments, the State must also have SSA 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 SSA 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 SSA 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 SSA, under which SSA will administer the State supplementary payments on behalf of a State (or political subdivision). Under such an agreement between SSA 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 SSA to be necessary for the effective and efficient administration of both the basic Federal benefit and the State supplementary payment. If the State elects options available under this subpart (specified in §§ 416.2015–416.2035), such options must be specified in the administration agreement.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 312, Jan. 3, 1997]

§ 416.2010 Essentials of the administration agreements.

(a) *Payments.* Any agreement between SSA 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) *Administrative costs.* (1) SSA shall assess each State that had elected Federal administration of optional and/or mandatory State supplementary payments an administration fee for administering those payments. The administration fee is assessed and paid monthly and is derived by multiplying the

number of State supplementary payments made by SSA on behalf of a State for any month in a fiscal year by the applicable dollar rate for the fiscal year. The number of supplementary payments made by SSA in a month is the total number of checks issued, and direct deposits made, to recipients in that month, that are composed in whole or in part of State supplementary funds. The dollar rates are as follows:

(i) For fiscal year 1994, $1.67;

(ii) For fiscal year 1995, $3.33;

(iii) For fiscal year 1996, $5.00;

(iv) For fiscal year 1997, $5.00;

(v) For fiscal year 1998, $6.20;

(vi) For fiscal year 1999, $7.60;

(vii) For fiscal year 2000, $7.80;

(viii) For fiscal year 2001, $8.10;

(ix) For fiscal year 2002, $8.50; and

(x) For fiscal year 2003 and each succeeding fiscal year—

(A) The applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(B) Such different rate as the Commissioner determines is appropriate for the State taking into account the complexity of administering the State's supplementary payment program.

(2) SSA shall charge a State an additional services fee if, at the request of the State, SSA agrees to provide the State with additional services beyond the level customarily provided in the administration of State supplementary payments. The additional services fee shall be in an amount that SSA determines is necessary to cover all costs, including indirect costs, incurred by the Federal Government in furnishing the additional services. SSA is not required to perform any additional services requested by a State and may, at its sole discretion, refuse to perform those additional services. An additional services fee charged a State may be a one-time charge or, if the furnished services result in ongoing costs to the Federal Government, a monthly or less frequent charge to the State for providing such services.

(c) *Agreement period.* The agreement period for a State which has elected Federal administration of its supplementary payments will extend for one year from the date the agreement was signed unless otherwise designated. The agreement will be automatically renewed for a period of one year unless either the State or SSA gives written notice not to renew, at least 90 days before the beginning of the new period. For a State to elect Federal administration, it must notify SSA 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.

(d) *Modification or termination.* The agreement may be modified at any time by mutual consent. The State or SSA 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 SSA where: (1) The State does not wish to comply with a regulation promulgated by SSA 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.

(e) *Mandatory minimum State supplementation.* Any administration agreement between SSA and a State under which SSA will make such State's mandatory minimum State supplementary payments shall provide that the State will:

(1) *Certify income and payment amount.* Certify to SSA 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 SSA with such additional data at such times as SSA 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.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 313, Jan. 3, 1997; 63 FR 33849, June 22, 1998]

§ 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 Commissioner 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; 62 FR 38455, July 18, 1997]

§ 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 Commissioner 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.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§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]

§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 416.586) 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.)

[40 FR 7640, Feb. 21, 1975, as amended at 65 FR 16815, Mar. 30, 2000]

§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 if for such month such individual resides in a State which SSA has determined provides supplementary payments the level of which has been found by SSA 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; 62 FR 313, Jan. 3, 1997]

§ 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 Commissioner under which such State shall provide mandatory minimum supplementary payments if such State has entered into an agreement with the Commissioner 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.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§416.2070 Mandatory supplementation: State compliance not applicable.

The requirement that a State must have in effect an agreement with the Commissioner 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 Commissioner, 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.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§416.2075 Monitoring of mandatory minimum supplementary payments.

(a) *Access to records.* Any State entering into an agreement with the Commissioner whereby such State will provide mandatory minimum supplementary payments in accordance with §416.2001(c) shall agree that the Commissioner 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 Commissioner with such additional data at such times as the Commissioner may

reasonably require in order to properly, economically, and efficiently be assessed of such State's compliance with such State agreements.

[40 FR 7640, Feb. 21, 1975, as amended at 62 FR 38455, July 18, 1997]

§ 416.2090 State funds transferred for supplementary payments.

(a) *Payment transfer and adjustment.* (1) Any State which has entered into an agreement with SSA which provides for Federal administration of such State's supplementary payments shall transfer to SSA:

(i) An amount of funds equal to SSA's estimate of State supplementary payments for any month which shall be made by SSA on behalf of such State; and

(ii) An amount of funds equal to SSA's estimate of administration fees for any such month determined in the manner described in § 416.2010(b)(1); and

(iii) If applicable, an amount of funds equal to SSA's determination of the costs incurred by the Federal government in furnishing additional services for the State as described in § 416.2010(b)(2).

(2) In order for SSA to make State supplementary payments on behalf of a State for any month as provided by the agreement, the estimated amount of State funds referred to in paragraph (a)(1)(i) of this section, necessary to make those payments for the month, together with the estimated amount of administration fees referred to in paragraph (a)(1)(ii) of this section, for that month, must be on deposit with SSA on the State supplementary payment transfer date, which is the fifth Federal business day following the day in the month that the regularly recurring monthly supplemental security income payments are issued. The additional services fee referred to in paragraph (a)(1)(iii) of this section shall be on deposit with SSA on the date specified by SSA. The amount of State funds paid to SSA for State supplementary payments and the amount paid for administration fees will be adjusted as necessary to maintain the balance with State supplementary payments paid out by SSA on behalf of the State, and administration fees owed to SSA, respectively.

(b) *Accounting of State funds.* (1) As soon as feasible, after the end of each calendar month, SSA will provide the State with a statement showing, cumulatively, the total amounts paid by SSA on behalf of the State during the current Federal fiscal year; the fees charged by SSA to administer such supplementary payments; any additional services fees charged the State; the State's total liability therefore; and the end-of-month balance of the State's cash on deposit with SSA.

(2) SSA shall provide an accounting of State funds received as State supplementary payments, administration fees, and additional services fees, within three calendar months following the termination of an agreement under § 416.2005.

(3) Adjustments 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. Interest will be incurred by SSA and the States with respect to the adjustment and accounting of State supplementary payments funds in accordance with applicable laws and regulations of the United States Department of the Treasury.

(c) *State audit.* Any State entering into an agreement with SSA 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 SSA 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 SSA 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 SSA.

(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.

[40 FR 7640, Feb. 21, 1975, as amended at 41 FR 36018, Aug. 26, 1976; 62 FR 313, Jan. 3, 1997]

§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 Commissioner concerning its supplementation programs so that the Commissioner 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, 1987, as amended at 54 FR 19165, May 4, 1989; 62 FR 38455, July 18, 1997]

§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 Commissioner. 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 §416.2090 of this part, 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.

(6) To determine whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of SSI benefits are not less than the State's expenditures for the payments in the preceding 12-month period, in computing the State's expenditures, we disregard, pursuant to a one-time election of the State, all expenditures by the State for the retroactive supplementary payments that are required to be made under the *Sullivan* v. *Zebley,* 493 U.S. 521 (1990) class action.

(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 Commissioner 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, 1987, as amended at 54 FR 19165, May 4, 1989; 56 FR 55453, Oct. 28, 1991; 62 FR 30984, June 6, 1997; 62 FR 38455, July 18, 1997; 65 FR 16815, Mar. 30, 2000]

§ 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, 1987, 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	
+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, 1987; 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 Commissioner shall provide appropriate and timely information to demonstrate to the Commissioner'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 Commissioner 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 Commissioner or someone designated by the Commissioner.

(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 Commissioner in effect, shall be determined by the Commissioner 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 Commissioner 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 Commissioner 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 Commissioner 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, 1987, as amended at 54 FR 19165, May 4, 1989; 62 FR 38455, July 18, 1997]

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 Social Security Administration.

[53 FR 12941, Apr. 20, 1988, as amended at 62 FR 38456, July 18, 1997]

Subpart V—Payments for Vocational Rehabilitation Services

AUTHORITY: Secs. 702(a)(5), 1615, 1631 (d)(1) and (e), and 1633(a) of the Social Security Act (42 U.S.C. 902(a)(5), 1382d, 1383 (d)(1) and (e), and 1683b(a)).

SOURCE: 48 FR 6297, Feb. 10, 1983, unless otherwise noted.

GENERAL PROVISIONS

§ 416.2201 General.

In general, sections 1615 (d) and (e) of the Social Security Act (the Act) authorize payment from the general fund for the reasonable and necessary costs of vocational rehabilitation (VR) services provided certain disabled or blind individuals who are eligible for supplemental security income (SSI) benefits, special SSI eligibility status, or federally administered State supplementary payments. In this subpart, such benefits, status, or payments are referred to as disability or blindness benefits (see § 416.2203). Subject to the provisions of this subpart, payment may be made for VR services provided an individual during a month(s) for which the individual is eligible for disability or blindness benefits, including the continuation of such benefits under section 1631(a)(6) of the Act, or for which the individual's disability or blindness benefits are suspended (see § 416.2215). Paragraphs (a),

(b) and (c) of this section describe the cases in which the State VR agencies and alternate participants can be paid for the VR services provided such an individual under this subpart. The purpose of sections 1615 (d) and (e) of the Act 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 benefits, even though his or her disability or blindness has ceased, under section 1631(a)(6) of the Act 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, as amended at 61 FR 31026, June 19, 1996]

§416.2202 Purpose and scope.

This subpart describes the rules under which the Commissioner 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; 62 FR 38456, July 18, 1997]

§ 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.

Disability or blindness benefits, as defined for this subpart only, refers to regular SSI benefits under section 1611 of the Act (see § 416.202), special SSI cash benefits under section 1619(a) of the Act (see § 416.261), special SSI eligibility status under section 1619(b) of the Act (see § 416.264), and/or a federally administered State supplementary payment under section 1616 of the Act or section 212(b) of Public Law 93–66 (see § 416.2001), for which an individual is eligible based on disability or blindness, as appropriate.

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.

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.

Special SSI eligibility status refers to the special status described in §§ 416.264 through 416.269 relating to eligibility for Medicaid.

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).

[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; 61 FR 31026, June 19, 1996; 62 FR 38456, July 18, 1997]

§ 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 benefits 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 benefits 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; 61 FR 31026, June 19, 1996]

§ 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 benefits based on participation in an approved VR program.

Section 1631(a)(6) of the 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 benefits because of his or her continued participation in an approved VR program. A VR agency or alternate participant can be paid for the cost of VR services provided to an individual if the individual was receiving benefits based on this provision in a month(s) after October 1984 or, in the case of a blindness recipient, in a month(s) after March 1988. 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, as amended at 61 FR 31026, June 19, 1996]

§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 prior to his or her VR refusal if the individual's disability or blindness benefits have been suspended

for a month(s) after October 1984 because of such VR refusal.

[59 FR 11919, Mar. 15, 1994, as amended at 61 FR 31026, June 19, 1996]

§ 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 a month(s) for which—

(i) The individual is eligible for disability or blindness benefits or continues to receive such benefits under section 1631(a)(6) of the Act (see §416.2212); or

(ii) The disability or blindness benefits of the individual are suspended due to his or her ineligibility for the benefits (see subpart M of this part concerning suspension for ineligibility); and

(3) Before completion of a continuous 9-month period of SGA or termination of disability or blindness benefits, whichever occurs first (see subpart M of this part concerning termination of benefits).

(b) If an individual who is receiving disability or blindness benefits under this part, or whose benefits under this part are suspended, also is entitled to disability benefits under part 404 of this chapter, the determination as to when services must have been provided may be made under this section or §404.2115 of this chapter, whichever is advantageous to the State VR agency or alternate participant that is participating in both VR programs.

[61 FR 31026, June 19, 1996]

§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.

(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 first month for which disability or blindness benefits are suspended because of such VR refusal.

[55 FR 8457, Mar. 8, 1990, as amended at 61 FR 31026, June 19, 1996]

§416.2217 What costs will be paid.

In accordance with section 1615 (d) and (e) of the Social Security Act, the Commissioner 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; 61 FR 31027, June 19, 1996; 62 FR 38456, July 18, 1997]

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 Appeals Board within 30 days after receiving it.

[48 FR 6297, Feb. 10, 1983, as amended at 55 FR 8458, Mar. 8, 1990; 62 FR 38456, July 18, 1997]

§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 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 Departmental Appeals Board.

(c) *Disputes on determinations made by the Commissioner which affect a disabled or blind beneficiary's rights to benefits.* Determinations made by the Commissioner 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 Commissioner 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; 62 FR 38456, July 18, 1997]

PART 422—ORGANIZATION AND PROCEDURES

Subpart A—Organization and Functions of the Social Security Administration

Sec.
422.1 Organization and functions.
422.5 District offices and branch offices.

Subpart B—General Procedures

422.101 Material included in this subpart.
422.103 Social security numbers.
422.104 To whom Social Security numbers are assigned.
422.105 Presumption of authority of nonimmigrant alien to accept employment.
422.106 Filing applications with other government agencies.
422.107 Evidence requirements.
422.108 Criminal penalties.
422.110 Individual's request for change in record.
422.112 Employer identification numbers.
422.114 Annual wage reporting process.
422.120 Earnings reported without a social security number or with an incorrect employee name or social security number.
422.122 Information on deferred vested pension benefits.
422.125 Statements of earnings; resolving earnings discrepancies.
422.130 Claim procedure.
422.135 Reports by beneficiaries.
422.140 Reconsideration of initial determination.

Subpart C—Procedures of the Office of Hearings and Appeals

422.201 Material included in this subpart.
422.203 Hearings.
422.205 Review by Appeals Council.
422.210 Judicial review.

Subpart D—Claims Collection

422.301 Material included in this subpart.
422.305 Report of overdue title II program overpayment debts to consumer reporting agencies.
422.306 Report of overdue administrative debts to credit reporting agencies.
422.310 Collection of overdue debts by administrative offset.
422.315 Review of our records related to the debt.
422.317 Review of the debt.

Subpart E [Reserved]

Subpart F—Applications and Related Forms

422.501 Applications and other forms used in Social Security Administration programs.
422.505 Applications and related forms for retirement, survivors, and disability insurance programs.
422.510 Applications and related forms used in the health insurance for the aged program.
422.512 Applications and related forms used in the black lung benefits program.
422.515 Forms used for withdrawal, reconsideration and other appeals, and appointment of representative.
422.520 Forms related to maintenance of earnings records.
422.525 Where applications and other forms are available.
422.527 Private printing and modification of prescribed applications and other forms.

Subpart G—Administrative Review Process Under the Coal Industry Retiree Health Benefit Act of 1992

422.601 Scope and purpose.
422.602 Terms used in this subpart.
422.603 Overview of the review process.
422.604 Request for detailed information.
422.605 Request for review.
422.606 Processing the request for review.
422.607 Limited reopening of assignments.

Subpart H—Use of SSA Telephone Lines

422.701 Scope and purpose.
422.705 When SSA employees may listen-in to or record telephone conversations.
422.710 Procedures SSA will follow.

SOURCE: 32 FR 13653, Sept. 29, 1967, unless otherwise noted.

Subpart A—Organization and Functions of the Social Security Administration

AUTHORITY: Secs. 205, 218, 221, and 701–704 of the Social Security Act (42 U.S.C. 405, 418, 421, and 901–904).

§ 422.1 Organization and functions.

(a) *General.* A complete description of the organization and functions of the Social Security Administration (pursuant to 5 U.S.C. 552(a), as amended by Pub. L. 90–23, the Public Information Act) was published in the FEDERAL REGISTER of July 15, 1967 (32 FR 10458), and was subsequently revised on April 16, 1968 (33 FR 5828), and amended on July 18, 1968 (33 FR 10292). Further amendments to or revisions of the description will be published in the FEDERAL REGISTER when and if required by changes in the organization or functions of the Social Security Administration. Such description (referred to as the SSA Statement of Organization, Functions, and Delegations of Authority) is printed and kept up to date in the Social Security Administration Organizational Manual, a copy of which is maintained in each district office and branch office of the Social Security Administration and is available for inspection and copying.

(b) *Information included in description.* This description includes information about the organization and functions of each component of the Social Security Administration. It also includes a listing of all district offices and branch offices within the organization of the Bureau of District Office Operations, and a listing of field offices within the organization of the Bureau of Hearings and Appeals where the public may secure information, make submittals or requests, or obtain decisions.

[34 FR 435, Jan. 11, 1969, as amended at 62 FR 38456, July 18, 1997]

§ 422.5 District offices and branch offices.

There are over 700 social security district offices and branch offices located in the principal cities and other urban areas or towns of the United States. In addition, there are over 3,300 contact stations, located in population and trading centers, which are visited on a regularly, recurring, preannounced basis. A schedule of these visits can be obtained from the nearest district office or branch office. The address of the nearest district office or branch office can be obtained from the local telephone directory or from the post office. Each district office and branch office has a list of all district offices and branch offices throughout the country and their addresses. The principal officer in each district office is the manager. The principal officer in each branch office is the officer-in-charge. Each district office and branch office also has a list of field offices of the Bureau of Hearings and Appeals and their addresses. The administrative hearing examiner is the principal officer in each field office. For procedures relating to claims see § 422.130, subpart J of part 404 of this chapter, and § 404.1520 of this chapter (the latter relating to disability determinations). For procedures on request for hearing by an Administrative Law Judge and review by the Appeals Council see subpart C of this part 422.

Subpart B—General Procedures

AUTHORITY: Secs. 205, 232, 702(a)(5), 1131, and 1143 of the Social Security Act (42 U.S.C. 405, 432, 902(a)(5), 1320b–1, and 1320b–13).

§ 422.101 Material included in this subpart.

This subpart describes the procedures relating to applications for and assignment of social security numbers, maintenance of earnings records of individuals by the Social Security Administration, requests for statements of earnings or for revision of earnings records, and general claims procedures, including filing of applications, submission of evidence, determinations, and reconsideration of initial determinations.

§ 422.103 Social security numbers.

(a) *General.* The Social Security Administration (SSA) maintains a record of the earnings reported for each individual assigned a social security number. The individual's name and social

security number identify the record so that the wages or self-employment income reported for or by the individual can be properly posted to the individual's record. Additional procedures concerning social security numbers may be found in Internal Revenue Service, Department of the Treasury regulation 26 CFR 31.6011(b)–2.

(b) *Applying for a number*—(1) *Form SS–5.* An individual needing a social security number may apply for one by filing a signed form SS–5, ''Application for A Social Security Number Card,'' at any social security office and submitting the required evidence. Upon request, the social security office may distribute a quantity of form SS–5 applications to labor unions, employers, or other representative organizations. An individual outside the United States may apply for a social security number card at the Department of Veterans Affairs Regional Office, Manila, Philippines, at any U.S. foreign service post, or at a U.S. military post outside the United States. (*See* § 422.106 for special procedures for filing applications with other government agencies.) Additionally, a U.S. resident may apply for a social security number for a nonresident dependent when the number is necessary for U.S. tax purposes or some other valid reason, the evidence requirements of § 422.107 are met, and we determine that a personal interview with the dependent is not required. Form SS–5 may be obtained at:

(i) Any local social security office;

(ii) The Social Security Administration, 300 N. Greene Street, Baltimore, MD 21201;

(iii) Offices of District Directors of Internal Revenue;

(iv) U.S. Postal Service offices (except the main office in cities having a social security office);

(v) U.S. Employment Service offices in cities which do not have a social security office;

(vi) The Department of Veterans Affairs Regional Office, Manila, Philippines;

(vii) Any U.S. foreign service post; and

(viii) U.S. military posts outside the U.S.

(2) *Birth registration document.* SSA may enter into an agreement with officials of a State, including, for this purpose, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and New York City, to establish, as part of the official birth registration process, a procedure to assist SSA in assigning social security numbers to newborn children. Where an agreement is in effect, a parent, as part of the official birth registration process, need not complete a form SS–5 and may request that SSA assign a social security number to the newborn child.

(3) *Immigration form.* SSA may enter into an agreement with the Department of State (DOS) and the Immigration and Naturalization Service (INS) to assist SSA by collecting enumeration data as part of the immigration process. Where an agreement is in effect, an alien need not complete a Form SS–5 with SSA and may request, through DOS or INS, as part of the immigration process, that SSA assign a social security number and issue a social security number card to him/her. Requests for SSNs to be assigned via this process will be made on forms provided by DOS and INS.

(c) *How numbers are assigned*—(1) *Request on form SS–5.* If the applicant has completed a form SS–5, the social security office, the Department of Veterans Affairs Regional Office, Manila, Philippines, the U.S. foreign service post, or the U.S. military post outside the United States that receives the completed form SS–5 will require the applicant to furnish documentary evidence, as necessary, to assist SSA in establishing the age, U.S. citizenship or alien status, true identity, and previously assigned social security number(s), if any, of the applicant. A personal interview may be required of the applicant. (See § 422.107 for evidence requirements.) After review of the documentary evidence, the completed form SS–5 is forwarded or data from the SS–5 is transmitted to SSA's central office in Baltimore, Md., where the data is electronically screened against SSA's files. If the applicant requests evidence to show that he or she has filed an application for a social security number card, a receipt or equivalent document may be furnished. If the electronic screening or other investigation does

not disclose a previously assigned number, SSA's central office assigns a number and issues a social security number card. If investigation discloses a previously assigned number for the applicant, a duplicate social security number card is issued.

(2) *Request on birth registration document.* Where a parent has requested a social security number for a newborn child as part of an official birth registration process described in paragraph (b)(2) of this section, the State vital statistics office will electronically transmit the request to SSA's central office in Baltimore, MD, along with the child's name, date and place of birth, sex, mother's maiden name, father's name (if shown on the birth registration), address of the mother, and birth certificate number. This birth registration information received by SSA from the State vital statistics office will be used to establish the age, identity, and U.S. citizenship of the newborn child. Using this information, SSA will assign a number to the child and send the social security number card to the child at the mother's address.

(3) *Request on immigration document.* Where an alien has requested a social security number as part of the immigration process described in paragraph (b)(3) of this section, INS will electronically transmit to SSA's central office in Baltimore, MD, the data elements collected for immigration purposes, by both INS and DOS, that SSA needs to assign the alien a social security number along with other data elements as agreed upon by SSA and DOS or INS. The data elements received by SSA will be used to establish the age, identity, and lawful alien status or authority to work of the alien. Using this data, SSA will assign a social security number to the alien and send the social security number card to him/her at the address the alien provides to DOS or INS (or to the sponsoring agency of a refugee, if no personal mailing address is available).

(d) *Social security number cards.* A person who is assigned a social security number will receive a social security number card from SSA within a reasonable time after the number has been assigned. (See § 422.104 regarding the assignment of social security number cards to aliens.) Social security number cards are the property of SSA and must be returned upon request.

(e) *Replacement of social security number card.* In the case of a lost or damaged social security number card, a duplicate card bearing the same name and number may be issued. In the case of a need to change the name on the card, a corrected card bearing the same number and the new name may be issued. In both cases, a Form SS–5 must be completed. A Form SS–5 can be obtained from any Social Security office or from one of the sources noted in paragraph (b) of this section. For evidence requirements, see § 422.107.

[55 FR 46664, Nov. 6, 1990, as amended at 63 FR 56554, Oct. 22, 1998]

§ 422.104 To whom Social Security numbers are assigned.

(a) *Persons with evidence of age, identity, and U.S. citizenship or alien status.* A Social Security number may be assigned to an applicant who meets the evidence requirements in § 422.107, if the applicant is:

(1) A U.S. citizen;

(2) An alien lawfully admitted to the United States for permanent residence or under other authority of law permitting him or her to work in the United States (see § 422.105 regarding presumption of authority of nonimmigrant alien to work); or

(3) An alien who is legally in the United States but not under authority of law permitting him or her to engage in employment, but only for a valid nonwork purpose. (See § 422.107.)

(b) *Persons without evidence of alien status.* A social security number may be assigned for a nonwork purpose to an alien who cannot provide the evidence of alien status as required by § 422.107(e), if the evidence described in that paragraph does not exist and if the alien resides either in or outside the United States and a social security number is required by law as a condition of the alien's receiving a federally-funded benefit to which the alien has established entitlement.

(c) *Annotation for a nonwork purpose.* If SSA has assigned a Social Security number for a nonwork purpose under the provision of paragraph (b)(1) or

(b)(2) of this section, SSA will annotate its record to show that the number has been assigned for a nonwork purpose. Additionally, the Social Security number card will be marked with a nonwork legend. If earnings are reported to SSA on a nonwork Social Security number which was assigned under a provision of this section, SSA will inform the Immigration and Naturalization Service of the reported earnings.

[56 FR 41790, Aug. 23, 1991, as amended at 63 FR 56554, Oct. 22, 1998]

§ 422.105 Presumption of authority of nonimmigrant alien to accept employment.

A nonimmigrant alien shall be presumed to have permission to engage in employment if the alien presents a Form I–94 issued by the Immigration and Naturalization Service (INS) that reflects a classification permitting work. (See 8 CFR 274a.12 for Form I–94 classifications.) A nonimmigrant alien who has not been issued a Form I–94, or whose Form I–94 does not reflect a classification permitting work, must submit a current document authorized by the INS that verifies authorization to work has been granted, e.g., an employment authorization document, to enable SSA to issue an SSN card that is valid for work purposes.

[63 FR 56554, Oct. 22, 1998]

§ 422.106 Filing applications with other government agencies.

(a) *Agreements.* In carrying out its responsibilities to assign social security numbers, SSA enters into agreements with the United States Attorney General, other Federal officials, and State and local welfare agencies. An example of these agreements is discussed in paragraph (b) of this section.

(b) *States.* SSA and a State may enter into an agreement that authorizes employees of a State or one of its subdivisions to accept social security number card applications from some individuals who apply for or are receiving welfare benefits under a State-administered Federal program. Under such an agreement, a State employee is also authorized to certify the application to show that he or she has reviewed the required evidence of the applicant's age, identity, and U.S. citizenship. The employee is also authorized to obtain evidence to assist SSA in determining whether the applicant has previously been assigned a number. The employee will then send the application to SSA which will issue a social security number card.

[55 FR 46665, Nov. 6, 1990, as amended at 63 FR 56555, Oct. 22, 1998]

§ 422.107 Evidence requirements.

(a) *General.* An applicant for an original social security number card must submit documentary evidence which the Commissioner of Social Security regards as convincing evidence of age, U.S. citizenship or alien status, and true identity. An applicant for a duplicate or corrected social security number card must submit convincing documentary evidence of identity and may also be required to submit convincing documentary evidence of age and U.S. citizenship or alien status. An applicant for an original, duplicate, or corrected social security number card is also required to submit evidence to assist us in determining the existence and identity of any previously assigned number(s). A social security number will not be assigned, or an original, duplicate, or corrected card issued, unless all the evidence requirements are met. An in-person interview is required of an applicant who is age 18 or older applying for an original social security number except for an alien who requests a social security number as part of the immigration process as described in § 422.103(b)(3). An in-person interview may also be required of other applicants. All documents submitted as evidence must be originals or certified copies of the original documents and are subject to verification with the custodians of the original records.

(b) *Evidence of age.* An applicant for an original social security number is required to submit convincing evidence of age. An applicant for a duplicate or corrected social security number card may also be required to submit evidence of age. Examples of the types of evidence which may be submitted are a birth certificate, a religious record showing age or date of birth, a hospital record of birth, or a passport. (*See* § 404.716.)

(c) *Evidence of identity.* An applicant for an original social security number or a duplicate or corrected social security number card is required to submit convincing documentary evidence of identity. Documentary evidence of identity may consist of a driver's license, identity card, school record, medical record, marriage record, passport, Immigration and Naturalization Service document, or other similar document serving to identify the individual. It is preferable that the document contain the applicant's signature for comparison with his or her signature on the application for a social security number. A birth record is not sufficient evidence to establish identity. Where the applicant is a child under 7 years of age applying for an original social security number card and there is no documentary evidence of identity available, the requirement for evidence of identity will be waived if there is no reason to doubt the validity of the birth record, the social security number application, and the existence of the individual. An applicant for a duplicate social security number card who is a U.S. citizen and who resides in an area where the Social Security Administration is conducting a pilot project on the issuance of duplicate cards will not be required to submit a signed application or corroborative documentary evidence of identity if the Social Security Administration is able to compare information provided by the applicant with information already in its records and, on the basis of this comparison, decides that corroborative documentary evidence is not needed to establish the applicant's identity. These special procedures do not apply to foreign-born U.S. citizens who have not already submitted evidence of citizenship to us; to a person applying on behalf of another if the applicant is not a parent applying on behalf of his or her minor child; and to people whose address is an in-care-of address, a post office box, general delivery, or a suite.

(d) *Evidence of U.S. citizenship.* Generally, an applicant for an original, duplicate, or corrected social security number card may prove that he or she is a U.S. citizen by birth by submitting a birth certificate or other evidence, as described in paragraphs (b) and (c) of this section, that shows a U.S. place of birth. Where a foreign-born applicant claims U.S. citizenship, the applicant for a social security number or a duplicate or corrected social security number card is required to present documentary evidence of U.S. citizenship. If required evidence is not available, a social security number card will not be issued until satisfactory evidence of U.S. citizenship is furnished. Any of the following is generally acceptable evidence of U.S. citizenship for a foreign-born applicant:

(1) Certificate of naturalization;

(2) Certificate of citizenship;

(3) U.S. passport;

(4) U.S. citizen identification card issued by the Immigration and Naturalization Service;

(5) Consular report of birth (State Department form FS–240 or FS–545); or

(6) Other verification from the Immigration and Naturalization Service, U.S. Department of State, or Federal or State court records confirming citizenship.

(e) *Evidence of alien status.* When a person who is not a U.S. citizen applies for an original social security number or a duplicate or corrected social security number card, he or she is required to submit, as evidence of alien status, a current document issued by the Immigration and Naturalization Service in accordance with that agency's regulations. The document must show that the applicant has been lawfully admitted to the United States, either for permanent residence or under authority of law permitting him or her to work in the United States, or that the applicant's alien status has changed so that it is lawful for him or her to work. If the applicant fails to submit such a document, a social security number card will not be issued. If the applicant submits an unexpired Immigration and Naturalization Service document(s) which shows current authorization to work, a social security number will be assigned or verified and a card which can be used for work will be issued. If the authorization of the applicant to work is temporary or subject to termination by the Immigration and Naturalization Service, the SSA records

may be so annotated. If the document(s) does not provide authorization to work and the applicant wants a social security number for a work purpose, no social security number will be assigned. If the applicant requests the number for a nonwork purpose and provides evidence documenting that the number is needed for a valid nonwork purpose, the number may be assigned and the card issued will be annotated with a nonwork legend. The SSA record will be annotated to show that a number has been assigned and a card issued for a nonwork purpose. In that case, if earnings are later reported to SSA, the Immigration and Naturalization Service will be notified of the report. SSA may also notify that agency if earnings are reported for a social security number that was valid for work when assigned but for which work authorization expired or was later terminated by the Immigration and Naturalization Service. SSA may also annotate the record with other remarks, if appropriate.

(f) *Failure to submit evidence.* If the applicant does not comply with a request for the required evidence or other information within a reasonable time, SSA may attempt another contact with the applicant. If there is still no response, a social security number card will not be issued.

(g) *Invalid or expired documents.* SSA will not issue an original, duplicate, or corrected social security number card when an applicant presents invalid or expired documents. Invalid documents are either forged documents that supposedly were issued by the custodian of the record, or properly issued documents that were improperly changed after they were issued. An expired document is one that was valid for only a limited time and that time has passed.

[55 FR 46665, Nov. 6, 1990, as amended at 60 FR 32446, June 22, 1995; 62 FR 38456, July 18, 1997; 63 FR 56555, Oct. 22, 1998]

§ 422.108 Criminal penalties.

A person may be subject to criminal penalties for furnishing false information in connection with earnings records or for wrongful use or misrepresentation in connection with social security numbers, pursuant to section 208 of the Social Security Act and sections of title 18 U.S.C. (42 U.S.C. 408; 18 U.S.C. 1001 and 1546).

[39 FR 10242, Mar. 19, 1974]

§ 422.110 Individual's request for change in record.

(a) *Form SS–5.* An individual who wishes to change the name or other personal identifying information previously submitted in connection with an application for a social security number card may complete and sign a Form SS–5 except as provided in paragraph (b) of this section. The person must prove his/her identity and may be required to provide other evidence. (See § 422.107 for evidence requirements.) A Form SS–5 may be obtained from any local social security office or from one of the sources noted in § 422.103(b). The completed request for change in records may be submitted to any SSA office, or, if the individual is outside the U.S., to the Department of Veterans Affairs Regional Office, Manila, Philippines, or to any U.S. foreign service post or U.S. military post. If the request is for a change in name, a new social security number card with the new name and bearing the same number previously assigned will be issued to the person making the request.

(b) *Assisting in enumeration.* SSA may enter into an agreement with officials of the Department of State and the Immigration and Naturalization Service to assist SSA by collecting as part of the immigration process information to change the name or other personal identifying information previously submitted in connection with an application or request for a social security number card. If the request is for a change in name, a new social security number card with the new name and bearing the same number previously assigned will be issued.

[63 FR 56555, Oct. 22, 1998]

§ 422.112 Employer identification numbers.

(a) *General.* Most employers are required by section 6109 of the Internal Revenue Code and by Internal Revenue Service (IRS) regulations at 26 CFR 31.6011(b)–1 to obtain an employer identification number (EIN) and to include

it on wage reports filed with SSA. A sole proprietor who does not pay wages to one or more employees or who is not required to file any pension or excise tax return is not subject to this requirement. To apply for an EIN, employers file Form SS–4, ''Application for Employer Identification Number,'' with the IRS. For the convenience of employers, Form SS–4 is available at all SSA and IRS offices. Household employers, agricultural employers, and domestic corporations which elect social security coverage for employees of foreign subsidiaries who are citizens or residents of the U.S. may be assigned an EIN by IRS without filing an SS–4.

(b) *State and local governments.* When a State submits a modification to its agreement under section 218 of the Act, which extends coverage to periods prior to 1987, SSA will assign a special identification number to each political subdivision included in that modification. SSA will send the State a Form SSA–214–CD, ''Notice of Identifying Number,'' to inform the State of the special identification number(s). The special number will be used for reporting the pre-1987 wages to SSA. The special number will also be assigned to an interstate instrumentality if pre-1987 coverage is obtained and SSA will send a Form SSA–214–CD to the interstate instrumentality to notify it of the number assigned.

[60 FR 42433, Aug. 16, 1995, as amended at 64 FR 33016, June 21, 1999]

§ 422.114 Annual wage reporting process.

(a) *General.* Under the authority of section 232 of the Act, SSA and IRS have entered into an agreement that sets forth the manner by which SSA and IRS will ensure that the processing of employee wage reports is effective and efficient. Under this agreement, employers are instructed by IRS to file annual wage reports with SSA on paper Forms W–2, ''Wage and Tax Statement,'' and Forms W–3, ''Transmittal of Income and Tax Statements,'' or equivalent W–2 and W–3 magnetic media reports. Special versions of these forms for Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Commonwealth of the Northern Mariana Islands are also filed with SSA. SSA processes all wage reporting forms for updating to SSA's earnings records and IRS tax records, identifies employer reporting errors and untimely filed forms for IRS penalty assessment action, and takes action to correct any reporting errors identified, except as provided in paragraph (c) of this section. SSA also processes Forms W–3c, ''Transmittal of Corrected Income Tax Statements,'' and W–2c, ''Statement of Corrected Income and Tax Amounts'' (and their magnetic media equivalents) that employers are required to file with SSA when certain previous reporting errors are discovered.

(b) *Magnetic media reporting requirements.* Under IRS regulations at 26 CFR 301.6011–2, employers who file 250 or more W–2 wage reports per year must file them on magnetic media in accordance with requirements provided in SSA publications, unless IRS grants the employer a waiver. Basic SSA requirements are set out in SSA's Technical Instruction Bulletin No. 4, ''Magnetic Media Reporting.'' Special filing requirements for U.S. territorial employers are set out in SSA Technical Instruction Bulletins No. 5 (Puerto Rico), No. 6 (Virgin Islands), and No. 7 (Guam and American Samoa). At the end of each year, SSA mails these technical instructions to employers (or third parties who file wage reports on their behalf) for their use in filing wage reports for that year.

(c) *Processing late and incorrect magnetic media wage transmittals.* If an employer's transmittal of magnetic media wage reports is received by SSA after the filing due date, SSA will notify IRS of the late filing so that IRS can decide whether to assess penalties for late filing, pursuant to section 6721 of the Internal Revenue Code. If reports do not meet SSA processing requirements (unprocessable reports) or are out of balance on critical money amounts, SSA will return them to the employer to correct and resubmit. In addition, beginning with wage reports filed for tax year 1993, if 90 percent or more of an employer's magnetic media wage reports have no social security numbers or incorrect employee names or social security numbers so that SSA is unable to credit their wages to its records,

SSA will not attempt to correct the errors, but will instead return the reports to the employer to correct and resubmit (see also § 422.120(b)). An employer must correct and resubmit incorrect and unprocessable magnetic media wage reports to SSA within 45 days from the date of the letter sent with the returned report. Upon request, SSA may grant the employer a 15-day extension of the 45-day period. If an employer does not submit corrected reports to SSA within the 45-day (or, if extended by SSA, 60-day) period, SSA will notify IRS of the late filing so that IRS can decide whether to assess a penalty. If an employer timely resubmits the reports as corrected magnetic media reports, but they are unprocessable or out of balance on W–2 money totals, SSA will return the resubmitted reports for the second and last time for the employer to correct and return to SSA. SSA will enclose with the resubmitted and returned forms a letter informing the employer that he or she must correct and return the reports to SSA within 45 days or be subject to IRS penalties for late filing.

(d) *Paper form reporting requirements.* The format and wage reporting instructions for paper forms are determined jointly by IRS and SSA. Basic instructions on how to complete the forms and file them with SSA are provided in IRS forms materials available to the public. In addition, SSA provides standards for employers (or third parties who file wage reports for them) to follow in producing completed reporting forms from computer software; these standards appear in SSA publication, ''Software Specifications and Edits for Annual Wage Reporting.'' Requests for this publication should be sent to: Social Security Administration, Office of Financial Policy and Operations, Attention: AWR Software Standards Project, P.O. Box 17195, Baltimore, MD 21235.

(e) *Processing late and incorrect paper form reports.* If SSA receives paper form wage reports after the due date, SSA will notify IRS of the late filing so that IRS can decide whether to assess penalties for late filing, pursuant to section 6721 of the Internal Revenue Code. SSA will ask an employer to provide replacement forms for illegible, incomplete, or clearly erroneous paper reporting forms, or will ask the employer to provide information necessary to process the reports without having to resubmit corrected forms. (For wage reports where earnings are reported without a social security number or with an incorrect name or social security number, see § 422.120.) If an employer fails to provide legible, complete, and correct W–2 reports within 45 days, SSA may identify the employers to IRS for assessment of employer reporting penalties.

(f) *Reconciliation of wage reporting errors.* After SSA processes wage reports, it matches them with the information provided by employers to the IRS on Forms 941, ''Employer's Quarterly Federal Tax Return,'' for that tax year. Based upon this match, if the total social security or medicare wages reported to SSA for employees is less than the totals reported to IRS, SSA will write to the employer and request corrected reports or an explanation for the discrepancy. If the total social security or medicare wages reported to SSA for employees is more than the totals reported to IRS, IRS will resolve the difference with the employer. If the employer fails to provide SSA with corrected reports or information that shows the wage reports filed with SSA are correct, SSA will ask IRS to investigate the employer's wage and tax reports to resolve the discrepancy and to assess any appropriate reporting penalties.

[60 FR 42433, Aug. 16, 1995]

§ 422.120 Earnings reported without a social security number or with an incorrect employee name or social security number.

(a) *Correcting an earnings report.* If an employer reports an employee's wages to SSA without the employee's social security number or with a different employee name or social security number than shown in SSA's records for him or her, SSA will write to the employee at the address shown on the wage report and request the missing or corrected information. If the wage report does not show the employee's address or shows an incomplete address,

SSA will write to the employer and request the missing or corrected employee information. SSA notifies IRS of all wage reports filed without employee social security numbers so that IRS can decide whether to assess penalties for erroneous filing, pursuant to section 6721 of the Internal Revenue Code. If an individual reports self-employment income to IRS without a social security number or with a different name or social security number than shown in SSA's records, SSA will write to the individual and request the missing or corrected information. If the employer, employee, or self-employed individual does not provide the missing or corrected report information in response to SSA's request, the wages or self-employment income cannot be identified and credited to the proper individual's earnings records. In such cases, the information is maintained in a ''Suspense File'' of uncredited earnings. Subsequently, if identifying information is provided to SSA for an individual whose report is recorded in the Suspense File, the wages or self-employment income then may be credited to his or her earnings record.

(b) *Returning incorrect reports.* SSA may return to the filer, unprocessed, an employer's annual wage report submittal if 90 percent or more of the wage reports in that submittal are unidentified or incorrectly identified. In such instances, SSA will advise the filer to return corrected wage reports within 45 days to avoid any possible IRS penalty assessment for failing to file correct reports timely with SSA. (See also § 422.114(c).) Upon request, SSA may grant the employer a 15-day extension of the 45-day period.

[60 FR 42434, Aug. 16, 1995]

§ 422.122 Information on deferred vested pension benefits.

(a) *Claimants for benefits.* Each month, SSA checks the name and social security number of each new claimant for social security benefits or for hospital insurance coverage to see whether the claimant is listed in SSA's electronic pension benefit record. This record contains information received from IRS on individuals for whom private pension plan administrators have reported to IRS, as required by section 6057 of the Internal Revenue Code, as possibly having a right to future retirement benefits under the plan. SSA sends a notice to each new claimant for whom it has pension benefit information, as required by section 1131 of the Act. If the claimant filed for the lump-sum death payment on the social security account of a relative, SSA sends the claimant the pension information on the deceased individual. In either case, SSA sends the notice after it has made a decision on the claim for benefits. The notice shows the type, payment frequency, and amount of pension benefit, as well as the name and address of the plan administrator as reported to the IRS. This information can then be used by the claimant to claim any pension benefits still due from the pension plan.

(b) *Requesting deferred vested pension benefit information from SSA files.* Section 1131 of the Act also requires SSA to provide available pension benefit information on request. SSA will provide this pension benefit information only to the individual who has the pension coverage (or a legal guardian or parent, in the case of a minor, on the individual's behalf). However, if the individual is deceased, the information may be provided to someone who would be eligible for any underpayment of benefits that might be due the individual under section 204(d) of the Act. All requests for such information must be in writing and should contain the following information: the individual's name, social security number, date of birth, and any information the requestor may have concerning the name of the pension plan involved and the month and year coverage under the plan ended; the name and address of the person to whom the information is to be sent; and the requester's signature under the following statement: ''I am the individual to whom the information applies (or ''I am related to the individual as his or her ''). I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.'' Such requests should be sent to: Social Security Administration, Office of Central Records Operations,

P.O. Box 17055, Baltimore, Maryland 21235.

[60 FR 42434, Aug. 16, 1995]

§ 422.125 Statements of earnings; resolving earnings discrepancies.

(a) *Obtaining a statement of earnings and estimated benefits.* An individual may obtain a statement of the earnings on his earnings record and an estimate of social security benefits potentially payable on his record either by writing, calling, or visiting any social security office, or by waiting until we send him one under the procedure described in § 404.812 of this chapter. An individual may request this statement by completing the proper form or by otherwise providing the information the Social Security Administration requires, as explained in § 404.810(b) of this chapter.

(b) *Statement of earnings and estimated benefits.* Upon receipt of such a request or as required by section 1143(c) of the Social Security Act, the Social Security Administration will provide the individual, without charge, a statement of earnings and benefit estimates or an earnings statement. See §§ 404.811 through 404.812 of this chapter concerning the information contained in these statements.

(c) *Detailed earnings statements.* A more detailed earnings statement will be furnished upon request, generally without charge, where the request is program related under § 402.170 of this part. If the request for a more detailed statement is not program related under § 402.170 of this part, a charge will be imposed according to the guidelines set out in § 402.175 of this part.

(d) *Request for revision of earnings records.* If an individual disagrees with a statement of earnings credited to his social security account, he may request a revision by writing to the Bureau of Data Processing and Accounts, Social Security Administration, Baltimore, MD 21235, or by calling at or writing to any social security district office or branch office or, if the individual is in the Philippines, by calling at or writing to the Veterans' Administration Regional Office, Manila, Philippines. Upon receipt of a request for revision, the Social Security Administration will initiate an investigation of the individual's record of earnings. Form OAR–7008, ''Statement of Employment for Wages and Self-Employment,'' is used by the Social Security Administration for obtaining information from the individual requesting a revision to aid the Administration in the investigation. These forms are available at any of the sources listed in this paragraph. If an individual receives a Form OAR–7008 from the Bureau of Data Processing and Accounts, the completed form should be returned to that office. In the course of the investigation the district office or branch office, where appropriate, contacts the employer and the employee or the self-employed individual, whichever is applicable, for the purpose of obtaining the information and evidence necessary to reconcile any discrepancy between the allegations of the individual and the records of the Administration. See subpart I of part 404 of this chapter for requirements for filing requests for revision, and for limitation on the revision of records of earnings.

(e) *Notice to individual of determination.* After the investigation has been completed and a determination affecting the individual's earnings record has been made, the Social Security Administration will notify the individual in writing of the status of his earnings record and inform him at the same time of the determination made in his case and of his right to a reconsideration if he is dissatisfied with such determination (see § 422.140).

(f) *Notice to individual of adverse adjustment of his account.* Written notice is given to an individual or his survivor in any case where the Social Security Administration adversely adjusts the individual's self-employment income. Where, subsequent to the issuance of a statement of earnings to an individual, an adverse adjustment is made of an amount of wages included in the statement, written notice of the adverse adjustment is given to the individual or his survivor. Written notice of the adverse adjustment is also given to the survivor if the statement of earnings had been given to such survivor. The individual or his survivor is requested to notify the Social Security Administration promptly if he disagrees, and he is informed that the adjustment will

become final unless he notifies the Administration of his disagreement (if any) within 6 months from the date of the letter, or within 3 years, 3 months, and 15 days after the year to which the adjustment relates, whichever is later.

[32 FR 13653, Sept. 29, 1967, as amended at 35 FR 7891, May 22, 1970; 35 FR 8426, May 29, 1970; 39 FR 26721, July 23, 1974; 41 FR 50998, Nov. 19, 1976; 50 FR 28568, July 15, 1985; 57 FR 54919, Nov. 23, 1992; 61 FR 18078, Apr. 24, 1996; 65 FR 16816, Mar. 30, 2000]

§ 422.130 Claim procedure.

(a) *General.* The Social Security Administration provides facilities for the public to file claims and to obtain assistance in completing them. An appropriate application form and related forms for use in filing a claim for monthly benefits, the establishment of a period of disability, a lump-sum death payment, or entitlement to hospital insurance benefits or supplementary medical insurance benefits can be obtained from any district office, branch office, contact station, or resident station of the Social Security Administration, from the Division of Foreign Claims, Post Office Box 1756, Baltimore, MD 21203, or from the Veteran's Administration Regional Office, Manila, Philippines. See § 404.614 of this chapter for offices at which applications may be filed. See 42 CFR part 405, subpart A, for conditions of entitlement to hospital insurance benefits and 42 CFR part 405, subpart B, for information relating to enrollment under the supplementary medical insurance benefits program.

(b) *Submission of evidence.* An individual who files an application for monthly benefits, the establishment of a period of disability, a lump-sum death payment, or entitlement to hospital insurance benefits or supplementary medical insurance benefits, either on his own behalf or on behalf of another, must establish by satisfactory evidence the material allegations in his application, except as to earnings shown in the Social Security Administration's records (see subpart H of part 404 of this chapter for evidence requirements in nondisability cases and subpart P of part 404 of this chapter for evidence requirements in disability cases). Instructions, report forms, and forms for the various proofs necessary are available to the public in district offices, branch offices, contact stations, and resident stations of the Social Security Administration, and the Veteran's Administration Regional Office, Manila, Philippines. These offices assist individuals in preparing their applications and in obtaining the proofs required in support of their applications.

(c) *Determinations and notice to individuals.* In the case of an application for benefits, the establishment of a period of disability, a lump-sum death payment, a recomputation of a primary insurance amount, or entitlement to hospital insurance benefits or supplementary medical insurance benefits, the Social Security Administration, after obtaining the necessary evidence, will make a determination as to the entitlement of the individual claiming or for whom is claimed such benefits, and will notify the applicant of the determination and of his right to a reconsideration if he is dissatisfied with the determination (see § 422.140). Also see § 404.1520 of this chapter for a discussion of the respective roles of State agencies and the Administration in the making of disability determinations and § 404.1521 of this chapter for information regarding initial determinations as to entitlement or termination of entitlement in disability cases. See section 1869(a) of the Social Security Act for determinations under the health insurance for the aged program and sections 1816 and 1842 of the Act for the role of intermediaries, carriers, and State agencies in performing certain functions under such program, e.g., payment of claims pursuant to an agreement with the Social Security Administration.

[32 FR 13653, Sept. 29, 1967, as amended at 44 FR 34942, June 18, 1979; 65 FR 16816, Mar. 30, 2000]

§ 422.135 Reports by beneficiaries.

(a) A recipient of monthly benefits and a person for whom a period of disability has been established are obligated to report to the Social Security Administration the occurrence of certain events which may suspend or terminate benefits or which may cause a cessation of a period of disability. (See

§§ 404.415 *et seq.* and 404.1571 of this chapter.)

(b) A person who files an application for benefits receives oral and written instructions about events which may cause a suspension or termination, and also appropriate forms and instruction cards for reporting such events. Pursuant to section 203(h)(1)(A) of the Act, under certain conditions a beneficiary must, within 3 months and 15 days after the close of a taxable year, submit to the Social Security Administration and annual report of his earnings and of any substantial services in self-employment performed during such taxable year. The purpose of the annual report is to furnish the Social Security Administration with information for making final adjustments in the payment of benefits for that year. An individual may also be requested to submit other reports to the Social Security Administration from time to time.

[32 FR 13653, Sept. 29, 1967, as amended at 65 FR 16816, Mar. 30, 2000]

§ 422.140 Reconsideration of initial determination.

Any part who is dissatisfied with an initial determination with respect to entitlement to monthly benefits, a lump-sum death payment, a period of disability, a revision of an earnings record, with respect to any other right under title II of the Social Security Act, or with respect to entitlement to hospital insurance benefits or supplementary medical insurance benefits, or the amount of hospital insurance benefits, may request that the Social Security Administration reconsider such determination. The information in § 404.1503 of this chapter as to the respective roles of State agencies and the Social Security Administration in the making of disability determinations is also generally applicable to the reconsideration of initial determinations involving disability. However, in cases in which a disability hearing as described in §§ 404.914 through 404.918 and 416.1414 through 416.1418 is available, the reconsidered determination may be issued by a disability hearing officer or by the Director of the Office of Disability Hearings or his or her delegate. After such initial determination has been reconsidered, the Social Security Administration will mail to each of the parties written notice and inform him or her of his right to a hearing before an administrative law judge (see § 422.201). Regulations relating to the details of reconsideration of initial determinations with respect to rights under title II of the Act or with respect to entitlement to hospital insurance benefits or supplementary medical insurance benefits may be found in part 404, subpart J of this chapter.

[51 FR 308, Jan. 3, 1986]

Subpart C—Procedures of the Office of Hearings and Appeals

AUTHORITY: Secs. 205, 221, and 702(a)(5) of the Social Security Act (42 U.S.C. 405, 421, and 902(a)(5)); 30 U.S.C. 923(b).

§ 422.201 Material included in this subpart.

This subpart describes in general the procedures relating to hearings before an administrative law judge of the Office of Hearings and Appeals, review by the Appeals Council of the hearing decision or dismissal, and court review. It also describes the procedures for requesting such hearing or Appeals Council review, and for instituting a civil action for court review. For detailed provisions relating to hearings before an administrative law judge, review by the Appeals Council, and court review, see the following references as appropriate to the matter involved:

(a) Title II of the Act, §§ 404.929 through 404.983 of this chapter;

(b) Title XVI of the Act, §§ 416.1429 through 416.1483 of this chapter;

(c) Title XVIII of the Act, 42 CFR 405.720 through 405.750, 498.17, 498.40 through 498.95, 417.260 through 417.263, 473.40 through 473.46, and 1001.128. For regulations relating to hearings under title XVIII for a provider of services dissatisfied with the intermediary's determination as to the amount of program reimbursement due to or from the provider, see 42 CFR 405.1809 through 405.1890. Such hearings are conducted by a hearing officer designated by the intermediary or by the Provider Reimbursement Review Board, as appropriate.

(d) Part B of title IV of the Federal Mine Safety and Health Act of 1977 as amended, §§ 410.630 through 410.670.

[41 FR 53791, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 54 FR 4268, Jan. 30, 1989]

§ 422.203 Hearings.

(a) *Right to request a hearing.* (1) After a reconsidered or a revised determination (i) of a claim for benefits or any other right under title II of the Social Security Act; or (ii) of eligibility or amount of benefits or any other matter under title XVI of the Act, except where an initial or reconsidered determination involving an adverse action is revised, after such revised determination has been reconsidered; or (iii) as to entitlement under part A or part B of title XVIII of the Act, or as to the amount of benefits under part A of such title XVIII (where the amount in controversy is $100 or more); or of health services to be provided by a health maintenance organization without additional costs (where the amount in controversy is $100 or more); or as to the amount of benefits under part B of title XVIII (where the amount in controversy is $500 or more); or as to a determination by a peer review organization (PRO) under title XI (where the amount in controversy is $200 or more); or as to certain determinations made under section 1154, 1842(1), 1866(f)(2), or 1879 of the Act; any party to such a determination may, pursuant to the applicable section of the Act, file a written request for a hearing on the determination. After a reconsidered determination of a claim for benefits under part B of title IV (Black Lung benefits) of the Federal Mine Safety and Health Act of 1977 (30 U.S.C. 921 through 925), a party to the determination may file a written request for hearing on the determination.

(2) After (i) a reconsidered or revised determination that an institution, facility, agency, or clinic does not qualify as a provider of services, or (ii) a determination terminating an agreement with a provider of services, such institution, facility, agency, or clinic may, pursuant to section 1866 of the Act, file a written request for a hearing on the determination.

(3) After (i) a reconsidered or revised determination that an independent laboratory, supplier of portable X-ray services, or end-stage renal disease treatment facility or other person does not meet the conditions for coverage of its services or (ii) a determination that it no longer meets such conditions has been made, such laboratory, supplier, treatment facility may, under 42 CFR 498.40 of this chapter, file a written request for a hearing on the determination. (For hearing rights of independent laboratories, suppliers of portable X-ray services, and end-stage renal disease treatment facilities and other person see 42 CFR 498.5.)

(b) *Request for hearing.* (1) A request for a hearing under paragraph (a) of this section may be made on Form HA–501, ''Request for Hearing,'' or Form HA–501.1, ''Request for Hearing, part A Hospital Insurance Benefits,'' or by any other writing requesting a hearing. The request shall be filed at an office of the Social Security Administration, usually a district office or a branch office, or at the Veterans' Administration Regional Office in the Philippines (except in title XVI cases), or at a hearing office of the Office of Hearings and Appeals, or with the Appeals Council. A qualified railroad retirement beneficiary may, if he prefers, file a request for a hearing under part A of title XVIII with the Railroad Retirement Board. Form HA–501 may be obtained from any social security district office or branch office, from the Office of Hearings and Appeals, Social Security Administration, P.O. Box 3200, Arlington, VA 22203, or from any other office where a request for a hearing may be filed.

(2) Unless for good cause shown an extension of time has been granted, a request for hearing must be filed within 60 days after the receipt of the notice of the reconsidered or revised determination, or after an initial determination described in 42 CFR 498.3 (b) and (c) (see §§ 404.933, 410.631, and 416.1433 of this chapter and 42 CFR 405.722, 498.40, and 417.260.)

(c) *Hearing decision or other action.* Generally, the administrative law judge will either decide the case after hearing (unless hearing is waived) or, if appropriate, dismiss the request for

hearing. With respect to a hearing on a determination under paragraph (a)(1) of this section, the administrative law judge may certify the case with a recommended decision to the Appeals Council for decision. If the determination on which the hearing request is based relates to the amount of benefits under part A or B of title XVIII of the Act, to health services to be provided by a health maintenance organization without additional costs, or to PRO determinations, the administrative law judge shall dismiss the request for hearing if he or she finds that the amount in controversy is less than $100 for appeals arising under part A or concerning health maintenance organization benefits; less than $200 for appeals arising from PRO determinations; and less than $500 for appeals arising under part B. Hearing decisions must be based on the evidence of record, under applicable provisions of the law and regulations and appropriate precedents.

[41 FR 53791, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 51 FR 308, Jan. 3, 1986; 54 FR 4268, Jan. 30, 1989]

§ 422.205 Review by Appeals Council.

(a) Any party to a hearing decision or dismissal may request a review of such action by the Appeals Council. The Health Care Financing Administration or, as appropriate, the Office of the Inspector General is a party to a hearing on a determination under § 422.203 (a)(2) and (a)(3) and to administrative appeals involving matters under section 1128(b)(6) of the Act (see 42 CFR 498.42). This request may be made on Form HA–520, ''Request for Review of Hearing Decision/Order,'' or by any other writing specifically requesting review. Form HA–520 may be obtained from any social security district office or branch office, from the Office of Hearings and Appeals Social Security Administration, P.O. Box 3200, Arlington, VA 22203, or at any other office where a request for a hearing may be filed. (For time and place of filing, see §§ 404.968, 410.661, and 416.1468 of this chapter, and 42 CFR 405.724, 498.82 and 417.261.)

(b) Whenever the Appeals Council reviews a hearing decision under §§ 404.967 or 404.969, 410.662, 416.1467, or 416.1469 of this chapter, or 42 CFR 405.724 or 417.261 or 473.46 and the claimant does not appear personally or through representation before the Council to present oral argument, such review will be conducted by a panel of not less than two members of the Council designated in the manner prescribed by the Chairman or Deputy Chairman of the Council. In the event of disagreement between a panel composed of only two members, the Chairman or Deputy Chairman, or his delegate, who must be a member of the Council, shall participate as a third member of the panel. When the claimant appears in person or through representation before the Council in the location designated by the Council, the review will be conducted by a panel of not less than three members of the Council designated in the manner prescribed by the Chairman or Deputy Chairman. Concurrence of a majority of a panel shall constitute the decision of the Appeals Council unless the case is considered as provided under paragraph (e) of this section.

(c) The denial of a request for review of a hearing decision concerning a determination under § 422.203(a)(1) shall be by such appeals officer or appeals officers or by such member or members of the Appeals Council as may be designated in the manner prescribed by the Chair or Deputy Chair. The denial of a request for review of a hearing dismissal, the dismissal of a request for review, the denial of a request for review of a hearing decision whenever such hearing decision after such denial would not be subject to judicial review as explained in § 422.210(a), or the refusal of a request to reopen a hearing or Appeals Council decision concerning a determination under § 422.203(a)(1) shall be by such member or members of the Appeals Council as may be designated in the manner prescribed by the Chair or Deputy Chair.

(d) A review or a denial of review of a hearing decision or a dismissal of a request for review with respect to requests by parties under 42 CFR 498.82 or 1001.128 in accordance with § 498.83 will be conducted by a panel of at least two members of the Appeals Council designated by the Chairman or Deputy Chairman and one person from the U.S.

Public Health Service designated by the Surgeon General, Public Health Service, Department of Health and Human Services, or his delegate. This person shall serve on an ad hoc basis and shall be considered for this purpose as a member of the Appeals Council. Concurrence of a majority of the panel shall constitute the decision of the Appeals Council unless the case is considered as provided under paragraph (e) of this section.

(e) On call of the Chairman, the Appeals Council may meet en banc or a representative body of Appeals Council members may be convened to consider any case arising under paragraph (b), (c), or (d) of this section. Such representative body shall be comprised of a panel of not less than five members designated by the Chairman as deemed appropriate for the matter to be considered, including a person from the U.S. Public Health Service in a matter under paragraph (d) of this section. The Chairman or Deputy Chairman shall preside, or in his absence, the Chairman shall designate a member of the Appeals Council to preside. A majority vote of the designated panel, or of the members present and voting shall constitute the decision of the Appeals Council.

(f) The Chairman may designate an administrative law judge to serve as a member of the Appeals Council for temporary assignments. An administrative law judge shall not be designated to serve as a member on any panel where such panel is conducting review on a case in which such individual has been previously involved.

[41 FR 53792, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 54 FR 4268, Jan. 30, 1989; 60 FR 7120, Feb. 7, 1995]

§ 422.210 Judicial review.

(a) *General.* A claimant may obtain judicial review of a decision by an administrative law judge if the Appeals Council has denied the claimant's request for review, or of a decision by the Appeals Council when that is the final decision of the Commissioner. A claimant may also obtain judicial review of a reconsidered determination, or of a decision of an administrative law judge, where, under the expedited appeals procedure, further administrative review is waived by agreement under §§ 404.926, 410.629d, or 416.1426 of this chapter or 42 CFR 405.718a–e as appropriate. For judicial review as to the amount of benefits under part A or part B of title XVIII of the Social Security Act, or of health services to be provided by a health maintenance organization without additional cost, the amount in controversy must be $1,000 or more as provided under section 1869(b) and section 1876(c)(5)(B) of the Act. For judicial review of a determination by a PRO, the amount in controversy must be $2,000 or more. An institution or agency may obtain judical review of a decision by the Appeals Council that it is not a provider of services, or of a decision by the Appeals Council terminating an agreement entered into by the institution or agency with the Commissioner (see section 1866(b)(2) of the Act). The Social Security Act does not provide for a right to judicial review of a final decision of the Commissioner regarding the status of an entity which is not a ''provider of services'', such as an independent laboratory. Providers of services or other persons may seek judicial review of a final administrative determination made pursuant to section 1128(b)(6) of the Act. There are no amount-in-controversy limitations on these rights of appeal.

(b) *Court in which to institute civil action.* Any civil action described in paragraph (a) of this section must be instituted in the district court of the United States for the judicial district in which the claimant resides or where such individual or institution or agency has his principal place of business. If the individual does not reside within any such judicial district, or if such individual or institution or agency does not have his principal place of business within any such judicial district, the civil action must be instituted in the District Court of the United States for the District of Columbia.

(c) *Time for instituting civil action.* Any civil action described in paragraph (a) of this section must be instituted within 60 days after the Appeals Council's notice of denial of request for review of the administrative law judge's decision or notice of the decision by the Appeals Council is received by the individual,

institution, or agency, except that this time may be extended by the Appeals Council upon a showing of good cause. For purposes of this section, the date of receipt of notice of denial of request for review of the presiding officer's decision or notice of the decision by the Appeals Council shall be presumed to be 5 days after the date of such notice, unless there is a reasonable showing to the contrary. Where pursuant to the expedited appeals procedures an agreement has been entered into under 42 CFR 405.718c, a civil action under section 205(g) of the Act must be commenced within 60 days from the date of the signing of such agreement by, or on behalf of, the Commissioner, except where the time described in the first sentence of this paragraph (c) has been extended by the Commissioner upon a showing of good cause. Where pursuant to the expedited appeals procedures an agreement has been entered into under §§404.926, 410.629d, or 416.1426 of this chapter, a civil action under section 205(g) of the Act must be commenced within 60 days after the date the individual receives notice (a signed copy of the agreement will be mailed to the individual and will constitute notice) of the signing of such agreement by, or on behalf of, the Commissioner, except where the time described in this paragraph (c) has been extended by the Commissioner upon a showing of good cause.

(d) *Proper defendant.* Where any civil action described in paragraph (a) of this section is instituted, the person holding the Office of the Commissioner shall, in his official capacity, be the proper defendant. Any such civil action properly instituted shall survive notwithstanding any change of the person holding the Office of the Commissioner or any vacancy in such office. If the complaint is erroneously filed against the United States or against any agency, officer, or employee of the United States other than the Commissioner, the plaintiff will be notified that he has named an incorrect defendant and will be granted 60 days from the date of receipt of such notice in which to commence the action against the correct defendant, the Commissioner.

[41 FR 53792, Dec. 9, 1976, as amended at 44 FR 34942, June 18, 1979; 49 FR 46370, Nov. 26, 1984; 49 FR 48036, Dec. 10, 1984; 54 FR 4268, Jan. 30, 1989; 62 FR 38456, July 18, 1997]

Subpart D—Claims Collection

AUTHORITY: Secs. 204(f), 205(a), and 702(a)(5) of the Social Security Act (42 U.S.C. 404(f), 405(a), and 902(a)(5)); 31 U.S.C. 3711(e); 31 U.S.C. 3716.

SOURCE: 62 FR 64278, Dec. 5, 1997, unless otherwise noted.

§ 422.301 Material included in this subpart.

This subpart describes the procedures relating to collection of:

(a) Overdue administrative debts, and

(b) Overdue title II program overpayments described in §404.527 of this chapter.

§ 422.305 Report of overdue title II program overpayment debts to consumer reporting agencies.

(a) *Debts we will report.* We will report to consumer reporting agencies all overdue title II program overpayment debts over $25.

(b) *Notice to debtor.* Before we report any such debt to a consumer reporting agency, we will send the debtor written notice of the following:

(1) We have determined that payment of the debt is overdue;

(2) We will refer the debt to a consumer reporting agency at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period, the debtor pays the full amount of the debt or takes either of the actions described in paragraphs (b)(6) or (b)(7) of this section;

(3) The specific information we will provide to the consumer reporting agency, including information that identifies the debtor (e.g., name, address, and social security number) and the amount, status, and history of the debt;

(4) The debtor has the right to a complete explanation of the debt;

(5) The debtor may dispute the accuracy of the information to be provided to the consumer reporting agency;

(6) The debtor may request a review of the debt by giving us evidence showing that he or she does not owe all or part of the amount of the debt or that we do not have the right to collect it; and

(7) The debtor may request an installment payment plan.

(c) *Disputing the information that we would send to consumer reporting agencies.* If a debtor believes that the information we propose to send to consumer reporting agencies is incorrect, the debtor may ask us to correct such information. If, within 60 calendar days from the date of our notice described in paragraph (b) of this section, the debtor notifies us that any information to be sent to consumer reporting agencies is incorrect, we will not send the information to consumer reporting agencies until we determine the correct information.

§ 422.306 Report of overdue administrative debts to credit reporting agencies.

(a) *Debts we will report.* We will report to credit reporting agencies all overdue administrative debts over $25. Some examples of administrative debts are as follows: overpayments of pay and allowances paid to employees, debts for civil monetary penalties imposed under section 1140(b) of the Act, debts for unpaid fees for reimbursable services performed by SSA (e.g., disclosures of information), and contractor debts.

(b) *Notice to debtor.* Before we report any administrative debt to a credit reporting agency, we will send the debtor written notice of the following:

(1) We have determined that payment of the debt is overdue;

(2) We will refer the debt to a credit reporting agency at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period, the debtor pays the full amount of the debt or takes either of the actions described in paragraphs (b)(6) or (b)(7) of this section;

(3) The specific information we will provide to the credit reporting agency, including information that identifies the debtor (e.g., name, address, social security number, and employer identification number) and the amount, status, and history of the debt;

(4) The debtor has the right to a complete explanation of the debt;

(5) The debtor may dispute the accuracy of the information to be provided to the credit reporting agency;

(6) The debtor may request a review of the debt by giving us evidence showing that he or she does not owe all or part of the amount of the debt or that we do not have the right to collect it; and

(7) The debtor may request an installment payment plan.

§ 422.310 Collection of overdue debts by administrative offset.

(a) *Referral to the Department of the Treasury for offset.* We will recover overdue debts by offsetting Federal payments due the debtor through the Treasury Offset Program (TOP). TOP is a Governmentwide delinquent debt matching and payment offset process operated by the Department of the Treasury, whereby debts owed to the Federal Government are collected by offsetting them against Federal payments owed the debtor.

(b) *Debts we will refer.* We will refer for administrative offset all overdue debts over $25.

(c) *Notice to debtor.* Before we refer any debt for collection by administrative offset, we will send the debtor written notice that:

(1) We have determined that payment of the debt is overdue;

(2) We will refer the debt for administrative offset at the expiration of not less than 60 calendar days after the date of the notice unless, within that 60-day period, the debtor pays the full amount of the debt or takes either of the actions described in paragraphs (c)(4) or (c)(5) of this section;

(3) The debtor may inspect or copy our records relating to the debt;

(4) The debtor may request a review of the debt by giving us evidence showing that the debtor does not owe all or part of the amount of the debt or that we do not have the right to collect it; and

(5) The debtor may request an installment payment plan.

§ 422.315 Review of our records related to the debt.

(a) *Notification by the debtor.* The debtor may request to inspect or copy our records related to the debt.

(b) *Our response.* In response to a request from the debtor described in paragraph (a) of this section, we will notify the debtor of the location and time at which the debtor may inspect or copy our records related to the debt. We may also, at our discretion, mail to the debtor copies of the records relating to the debt.

§ 422.317 Review of the debt.

(a) *Notification and presentation of evidence by the debtor.* A debtor who receives a notice described in § 422.305(b), § 422.306(b), or § 422.310(c) has a right to have us review the debt. To exercise this right, within 60 calendar days from the date of our notice, the debtor must notify us and give us evidence that he or she does not owe all or part of the debt or that we do not have the right to collect it. If the debtor does not notify us and give us this evidence within the 60 calendar-day period, we may take the action described in our notice.

(b) *Review of the evidence.* If the debtor notifies us and presents evidence within the 60 calendar-day period described in paragraph (a) of this section, we will not take the action described in our notice unless and until we consider all of the evidence and send the debtor our findings that all or part of the debt is overdue and legally enforceable.

(c) *Findings by SSA.* Following our review of all of the evidence presented, we will issue written findings, including the supporting rationale for the findings. Issuance of these findings will be the final Agency action on the debtor's request for review. If we find that the debt is not overdue or we do not have the right to collect it, we will not send information about the debt to consumer or other credit reporting agencies or refer the debt to the Department of the Treasury for administrative offset.

Subpart E [Reserved]

Subpart F—Applications and Related Forms

AUTHORITY: Secs. 205 and 702(a)(5) of the Social Security Act (42 U.S.C. 405 and 902(a)(5)). Section 422.512 is also issued under 30 U.S.C. 901 *et seq.*

§ 422.501 Applications and other forms used in Social Security Administration programs.

This subpart lists the applications and some of the related forms prescribed by the Social Security Administration for use by the public in applying for benefits under titles II and XVIII of the Social Security Act and the black lung benefits program (Part B, title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended).

[38 FR 11450, May 8, 1973]

§ 422.505 Applications and related forms for retirement, survivors, and disability insurance programs.

(a) *Applications.* To facilitate claims taking, the Social Security Administration (SSA) has designed applications to be used by the public when claiming benefits under title II of the Social Security Act. Prescribed applications include our traditional printed forms and our computer printouts. The printouts are similar in content to the traditional application, forms, but are produced only after an SSA employee has keyed into a computer terminal the answers the applicant has given to the relevant questions. The information on the applications includes such items as date of birth, family relationship, work history, etc. The printout may omit questions that the computer recognizes as irrelevant as a result of the answers to other questions. Phrasing may differ from that on the traditional printed forms.

(b) *Related forms.* The following are some related forms:

SSA–3—Husband's Certification. (For use in connection with Application for Wife's Insurance Benefits, Form SSA–2.)

SSA–8a—Supplement to Form SSA–8 (Application for Lump-Sum Death Payment). (For use with a funeral home's application for lump-sum death payment, Form SSA–8).

SSA–11—Application to be Selected as Payee. (For use when the individual proposing to be substituted for current payee files application to receive payment of benefits on behalf of himself, a disabled child or child under age 22, a student beneficiary, or an incompetent beneficiary.)

SSA–15—Wife's Certification. (For use in connection with Application for Husband's Insurance Benefits, Form SSA–14.)

SSA–17—Statement Regarding Disability (By Widow, Widower, Surviving Divorced Wife, or Child). (For use in connection with a request for payment of benefits due to disability by a widow, widower, surviving divorced wife, or a child who is age 18 or over and is under a disability which began before age 22.)

SSA–21—Supplement to Claim of Person Outside of the United States. (To be completed by or on behalf of a person who is, was, or will be outside the United States.)

SSA–22—Supplement to Claim on Behalf of Child Outside the United States. (To be completed for a child who is, was, or will be outside the United States.)

SSA–25—Certificate of Election for Reduced Wife's Benefits. (For use by a wife age 62 through 64 who has an entitled child in her care and elects to receive reduced benefits for months during which she will not have a child in her care.)

SSA–401—Medical History and Disability Report.

SSA–401A—Report of Disability Interview—Widow (Divorced Wife) and Widower.

SSA–401CH—Report of Childhood Disability Interview. (Forms SSA–401, SSA–401A, and SSA–401CH are for use in documenting a claimant's medical history together with the course and effects of the claimant's vocational history.)

SSA–717—Statement of Person Requesting Payment on Behalf of Estate.

SSA–718—Consent by Relative for Payment to Individual on Behalf of Estate.

SSA–719—Statement of Burial Expenses by Funeral Director. (To be completed by the funeral director in connection with an individual's (other than a widow or widower who was living in the same household with the insured individual at the time of his death) application authorizing direct payment of the lump-sum death payment to the funeral director.) (See Form SSA–8 under § 422.505(a).)

SSA–721—Statement of Death by Funeral Director. (This form may be used as evidence of death (see § 404.704 of this chapter).)

SSA–760—Certificate of Support (Parent's, Husband's, or Widower's).

SSA–766—Statement of Self-Employment Income. (For use by a claimant to establish insured status based on self-employment income in the current year.)

SSA–780—Certificate of Applicant for Benefits on Behalf of Another. (This form accompanies an individual's or institution's request to be selected payee for a beneficiary and is used to determine the requester's interest in the welfare of the beneficiary.)

SSA–786—Physician's Statement. (For use in requesting medical evidence of a beneficiary's capacity to manage benefits.)

SSA–787—Medical Officer's Statement. (For use in requesting medical evidence of a beneficiary's capacity to manage benefits from an institution.)

SSA–823—Request for Medical Evidence to Hospital or Institution. (For use in requesting information regarding hospitalization or treatment of a disability claimant.)

SSA–824—Report on Individual With Mental Impairment. (For use in requesting information regarding a disability claimant's mental impairment.)

SSA–826—Medical Report—General. (For use in obtaining medical information concerning a disability claimant.)

SSA–826.1—Medical Report—Pulmonary Tuberculosis. (For use in requesting medical evidence from a hospital in which a disability claimant is confined for the treatment of tuberculosis.)

SSA–827—Applicant's Request for Medical Information. (To be completed by a disability claimant to authorize release of medical information.)

SSA–1001—Statement of Employer. (For use by an employer to provide evidence of quarterly wage payments.)

SSA–1002—Statement of Agricultural Employer. (For use by an employer to provide evidence of annual wage payments for agricultural work.)

SSA–1372—Student's Statement Regarding School Attendance. (For use in connection with a request for payment of child's insurance benefits for a child who is age 18 through 21 and a full-time student.)

SSA–1372A—Certification by School Official of Student's Full-time Attendance. (For use with requests for child's insurance benefits for students age 18 through 21.)

SSA–1372A(F)—Statement to U.S. Social Security Administration by School Outside the United States About Student's Attendance. (For use in connection with a request for payment of child's insurance benefits for a child who is age 18 through 21 and a full-time student outside the United States.)

SSA–1388—Report of Student Beneficiary at End of School Year. (For use in confirming continuing eligibility to benefits or indicating the need for suspension or termination action.)

SSA–1442—Statement by Divorced Woman Regarding Contributions and Support From Her Former Husband.

SSA–1724—Claim for Amounts Due in the Case of a Deceased Beneficiary. (For use in

requesting amounts payable under title II to a deceased beneficiary.)

SSA–4111—Certificate of Election for Reduced Widow(er)'s Benefits. (For use by applicants for certain reduced widow's or widower's benefits.)

SSA–7156—Farm Self-Employment Questionaire. (For use in connection with claims for benefits based on farm income to determine whether the income is covered under the Social Security Act.)

SSA–7160—Employment Relationship Questionnaire. (For use by an individual and the alleged employer to determine the individual's employment status.)

DDS–7163—Questionnaire About Employment or Self-Employment Outside United States. (To be completed by or on behalf of a beneficiary who is, was, or will be employed or self-employed outside the United States.)

SSA–7203—Sick Pay and Plan or System Questionnaire. (To be completed by an employer for the purpose of determining the nature of special payments to an employee.)

[38 FR 11450, May 8, 1973, as amended at 51 FR 41952, Nov. 20, 1986; 55 FR 25826, June 25, 1990]

§ 422.510 Applications and related forms used in the health insurance for the aged program.

(a) *Application forms.* The following forms are prescribed for use in applying for entitlement to benefits under the health insurance for the aged program:

SSA–18—Application for Hospital Insurance Entitlement. (For use by individuals who are not entitled to retirement benefits under title II of the Social Security Act or under the Railroad Retirement Act. This form may also be used for enrollment in the supplementary medical insurance benefits plan.)

SSA–40—Application for Enrollment in the Supplementary Medical Insurance Program. (This form is mailed directly to beneficiaries at the beginning of their initial enrollment period.)

SSA–40A—Application for Enrollment in Supplementary Medical Insurance. (For use by civil service employees who are not eligible for enrollment in the hospital insurance plan.)

SSA–40B—Application for Medical Insurance. (For general use in requesting medical insurance protection.)

SSA–40C—Application for Enrollment. (This form is mailed to beneficiaries as a followup on Form SSA–40 (Application for Enrollment in the Supplementary Medical Insurance Program).)

SSA–40F—Application for Medical Insurance. (For use by beneficiaries residing outside the United States.)

An individual who upon attainment of age 65 is entitled to a monthly benefit based on application OA–C1, SSA–2, OA–C7, OA–C10, SSA–10A, OA–C13, or SSA–14 is automatically entitled to hospital insurance protection. (For conditions of entitlement to hospital insurance benefits, see 42 CFR part 405, subpart A. For medical insurance protection, an applicant must request supplementary medical insurance coverage (see Forms SSA–40, SSA–40A, SSA–40B, SSA–40C, and SSA–40F under § 422.510(a)). (For conditions of entitlement to supplementary medical insurance benefits, see 42 CFR part 405, subpart B.)

(b) *Related forms.* The following are the prescribed forms for use in requesting payment for services under the hospital insurance benefits program and the supplementary medical insurance benefits program and other related forms:

SSA–1453—Inpatient Hospital and Extended Care Admission and Billing. (To be completed by hospital for payment of hospital expenses for treatment of patient confined in hospital.)

SSA–1483—Provider Billing for Medical and Other Health Services. (To be completed by hospital for payment of hospital expenses for treatment of patient who is not confined in the hospital.)

SSA–1484—Explanation of Accommodation Furnished. (To be completed by the hospital to explain accommodation of a patient in other than a semiprivate (two- to four-bed) room.)

SSA–1486—Inpatient Admission and Billing—Christian Science Sanatorium. (To be completed by a Christian Science sanatorium for payment for treatment of patients confined in the sanatorium.)

SSA–1487—Home Health Agency Report and Billing. (For use by an organization providing home health services.)

SSA–1490—Request for Medicare Payment. (For use by patient or physician to request payment for medical expenses.)

SSA–1554—Provider Billing for Patient Services by Physicians. (For use by hospital for payment for services provided by hospital-based physicians.)

SSA–1556—Prepayment Plan for Group Medical Practices Dealing Through a Carrier. (For use by organizations (which have been

determined to be group practice prepayment plans for medicare purposes) for reimbursement for medical services provided to beneficiaries.)

SSA–1660—Request for Information—Medicare Payment For Services to a Patient Now Deceased. (For use in requesting amounts payable under title XVIII to a deceased beneficiary.)

SSA–1739—Request for Enrollment Card Information by Foreign Beneficiary. (Used to notify beneficiaries approaching age 65 who reside in foreign countries that they are eligible to enroll for SMI. They return this form if they wish additional information and an application, SSA–40F.)

SSA–1966—Health Insurance Card. (This card is issued to a person entitled to benefits under the health insurance for the aged program and designates whether he is entitled to hospital insurance benefits or supplementary medical insurance benefits or both.

SSA–1980—Carrier or Intermediary Request for SSA Assistance.

SSA–2384—Third Party Premium Billing Request. (For use by a nonbeneficiary enrollee who must pay premiums by direct remittance and is having his premium notices sent to a third party to assure continuance of supplementary medical insurance.)

[32 FR 18030, Dec. 16, 1967, as amended at 38 FR 11451, May 8, 1973; 44 FR 34943, June 18, 1979]

§ 422.512 Applications and related forms used in the black lung benefits program.

(a) *Application forms.* The following forms are prescribed for use in applying for entitlement to benefits under part B of title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972:

SSA–46—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Coal Miner's Claim of Total Disability).

SSA–47—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Widow's Claim).

SSA–48—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Child's Claim).

SSA–49—Application for Benefits Under the Federal Coal Mine Health and Safety Act of 1969, as Amended (Parent's, Brother's and Sister's Claim).

(b) *Related forms.* The following are some related forms:

SSA–50—Request To Be Selected as Payee. (For use when the individual proposing to be substituted for current payee files application to receive payment of black lung benefits on behalf of himself, a disabled child or child under age 18, a student beneficiary, or an incompetent beneficiary.)

SSA–2179—Report by Person Entitled to Black Lung Benefits. (For use by person entitled to black lung benefits to report events which affect benefits.)

SAA–2210—Statement of Coal Mine Employment by United Mine Workers of America.

SSA–2325—Medical Report (Pneumoconiosis).

[38 FR 11451, May 8, 1973]

§ 422.515 Forms used for withdrawal, reconsideration and other appeals, and appointment of representative.

The following is a list of forms prescribed by the Social Security Administration for use by the public to request a withdrawal of an application, a reconsideration of an initial determination, a hearing, a review of an administrative law judge's decision, or for use where a person is authorized to represent a claimant.

SSA–521—Request for Withdrawal of Application. (For use by an individual to cancel his application.)

SSA–561—Request for Reconsideration. (For use by an individual who disagrees with an initial determination concerning (a) entitlement to benefits or any other right under title II of the Social Security Act, or (b) entitlement to hospital insurance benefits or supplementary medical insurance benefits under title XVIII of the act, or (c) entitlement to black lung benefits under title IV of the Federal Coal Mine Health and Safety Act. See § 422.140 for a discussion of the reconsideration procedure.)

SSA–1696—Appointment of Representative. (For use by person other than an attorney authorized by a claimant to act for him in a claim or related matter.)

SSA–1763—Request for Termination of Supplementary Medical Insurance. (For use by an enrollee in requesting that his supplementary medical insurance coverage be terminated.)

SSA–1965—Request for Hearing—Part B Medicare Claim. (For use by an individual enrollee or his assignee to obtain a hearing before a hearing officer designated by the carrier concerning benefits payable under part B of title XVIII.)

HA–501—Request for Hearing. (For use by an individual or institution to obtain a hearing on a claim for title II benefits before an administrative law judge of the Social Security Administration.)

NOTE: This form is also used to request a hearing regarding entitlement to hospital insurance benefits or supplementary medical insurance benefits under title XVIII of the act. (See § 422.203 for a discussion of the hearing procedure.)

HA–501.1—Request for Hearing—Part A Health Insurance. (For use by an individual or institution to obtain a hearing before an administrative law judge of the Social Security Administration concerning the amount of hospital insurance benefits under title XVIII.)

HA–512.1—Notice by Attorney of Appointment as Representative. (For use by an attorney authorized by a claimant to act for him in a claim or related matter.)

HA–520—Request for Review of Hearing Examiner's Action. (For use by an individual or institution to obtain a review of a decision by an administrative law judge of the Social Security Administration.)

[38 FR 11452, May 8, 1973]

§ 422.520 Forms related to maintenance of earnings records.

The following forms are used by the Social Security Administration and by the public in connection with the maintenance of earnings records of wage-earners and self-employed persons:

SS–4—Application for Employer Identification Number.

SS–4A—Agricultural Employer's Application. (For use by employers of agricultural workers to request an employer identification number under the FICA.)

SS–5—Application for a Social Security Number (or Replacement of Lost Card).

SS–15—Certificate Waiving Exemption From Taxes Under the FICA. (For use by certain nonprofit organizations requesting coverage of its employees.)

SS–15a—List of Concurring Employees. (To be signed by each employee who concurs in the filing of the Certificate Waiving Exemption From Taxes Under the FICA, Form SS–15.)

SSI–21—Social Security and Your Household Employee. (For use by employers of household workers to request information from the Internal Revenue Service Center regarding filing employee tax returns.)

OA–702—Social Security Number Card.

Form 2031—Waiver Certificate To Elect Social Security Coverage for Use by Ministers, Certain Members of Religious Orders, and Christian Science Practitioners.

Form 4029—Application for Exemption from Tax on Self-Employment Income and Waiver of Benefits. (To be completed by self-employed individuals who are members of certain recognized religious sects (or division thereof) and do not wish to pay FICA taxes or participate in the programs provided under titles II and XVIII.)

Form 4361—Application for Exemption From Self-Employment Tax for Use by Ministers, Members of Religious Orders, and Christian Science Practitioners.

Form 4415—Election To Exempt From Self-Employment Coverage Fees Received by Certain Public Officers and Employees of a State or Political Subdivision Thereof.

OAAN–5028—Evidence of Application for Social Security Number Card.

OAAN–7003—Request for Change in Social Security Records. (For use by an individual to change information given on original application for a social security number.)

OAR–7004—Request for Statement of Earnings. (For use by worker to obtain a statement of earnings recorded in his earnings record.)

OAR–7008—Request for Correction of Earnings Record. (For use by an individual who wishes to have his earnings record revised.)

SSA–7011—Statement of Employer. (For use by an employer to provide evidence of wage payments in cases of a wage discrepancy in an individual's earnings record.)

[38 FR 11452, May 8, 1973]

§ 422.525 Where applications and other forms are available.

All applications and related forms prescribed for use in the programs administered by the Social Security Administration pursuant to the provisions of titles II and XVIII of the act, and part B of title IV of the Federal Coal Mine Health and Safety Act of 1969 are printed under the specifications of the Administration and distributed free of charge to the public, institutions, or organizations for the purposes described therein. All prescribed forms can be obtained upon request from any social security district office or branch office (see § 422.5). Forms appropriate for use in requesting payment for services provided under the health insurance for the aged and disabled programs can also be obtained from the intermediaries or carriers (organizations under contract with the Social Security Administration to make payment for such services) without charge. Form 2031 (Waiver Certificate to Elect Social Security Coverage for Use by Ministers, Certain Members of Religious Orders, and Christian Science Practitioners), Form 4029 (Application for Exemption From

Tax on Self-Employment Income and Waiver of Benefits), Form 4361 (Application for Exemption From Self-Employment Tax for Use by Ministers, Members of Religious Orders, and Christian Science Practitioners), Form 4415 (Election to Exempt From Self-Employment Coverage Fees Received by Certain Public Officers and Employees of a State or a Political Subdivision Thereof), Form SS–4 (Application for Employer Identification Number), Form SS–4A (Agricultural Employer's Application for Identification Number), Form SS–5 (Application for a Social Security Number (or Replacement of Lost Card)), Form SS–15 (Certificate Waiving Exemption From Taxes Under the FICA), and Form SS–15a (List of Concurring Employees) can also be obtained without charge from offices of the Internal Revenue Service. For other offices where applications and certain other forms can be obtained, see subparts B and C of this part 422.

[38 FR 11452, May 8, 1973]

§ 422.527 Private printing and modification of prescribed applications and other forms.

Any person, institution, or organization wishing to reproduce, duplicate, or privately print any application or other form prescribed by the Administration should obtain the prior approval of the Administration. Requests for approval to so reproduce any prescribed form must be in writing and include the reason or need for such reproduction, the intended user of the form, the proposed modifications, if any, the proposed format, with printing or other specifications, the type of automatic data processing machinery (e.g., printer, burster, mail handling), if any, for which the form is being designed, estimated printing quantity, estimated cost per thousand, estimated annual usage, and such other pertinent information as may be required by the Administration. All requests are to be forwarded to: Social Security Administration, Printing and Records Management Branch, Baltimore, MD 21235.

[33 FR 11281, Aug. 8, 1968]

Subpart G—Administrative Review Process Under the Coal Industry Retiree Health Benefit Act of 1992

AUTHORITY: 26 U.S.C. 9701–9708.

SOURCE: 58 FR 52916, Oct. 13, 1993, unless otherwise noted.

§ 422.601 Scope and purpose.

The regulations in this subpart describe how the Social Security Administration (SSA) will conduct reviews of assignments it makes under provisions of the Coal Industry Retiree Health Benefit Act of 1992 (the Coal Act). Under the Coal Act, certain retired coal miners and their eligible family members (beneficiaries) are assigned to particular coal operators (or related persons). These operators are then responsible for paying the annual health and death benefit premiums for these beneficiaries as well as the annual premiums for certain unassigned coal miners and eligible members of their families. We will notify the assigned operators of these assignments and give each operator an opportunity to request detailed information about an assignment and to request review of an assignment. We also inform the United Mine Workers of America (UMWA) Combined Benefit Fund Trustees of each assignment made and the unassigned beneficiaries so they can assess appropriate annual premiums against the assigned operators. This subpart explains how assigned operators may request such additional information, how they may request review of an assignment, and how reviews will be conducted.

§ 422.602 Terms used in this subpart.

Assignment means our selection of the coal operator or related person to be charged with the responsibility of paying the annual health and death benefit premiums of certain coal miners and their eligible family members.

Beneficiary means either a coal industry retiree who, on July 20, 1992, was eligible to receive, and receiving, benefits as an eligible individual under the 1950 or the 1974 UMWA Benefit Plan, or an individual who was eligible to receive, and receiving, benefits on July

20, 1992 as an eligible relative of a coal industry retiree.

Evidence of a prima facie case of error means documentary evidence, records, and written statements submitted to us by the assigned operator (or related person) that, standing alone, shows our assignment was in error. The evidence submitted must, when considered by itself without reference to other contradictory evidence that may be in our possession, be sufficient to persuade a reasonable person that the assignment was erroneous. Examples of evidence that may establish a prima facie case of error include copies of Federal, State, or local government tax records; legal documents such as business incorporation, merger, and bankruptcy papers; health and safety reports filed with Federal or State agencies that regulate mining activities; payroll and other employment business records; and information provided in trade journals and newspapers.

A related person to a signatory operator means a person or entity which as of July 20, 1992, or, if earlier, the time immediately before the coal operator ceased to be in business, was a member of a controlled group of corporations which included the signatory operator, or was a trade or business which was under common control with a signatory operator, or had a partnership interest (other than as a limited partner) or joint venture with a signatory operator in a business within the coal industry which employed eligible beneficiaries, or is a successor in interest to a person who was a related person.

We or *us* refers to the Social Security Administration.

You as used in this subpart refers to the coal operator (or related person) assigned premium responsibility for a specific beneficiary under the Coal Act.

[58 FR 52916, Oct. 13, 1993, as amended at 62 FR 38456, July 18, 1997]

§ 422.603 Overview of the review process.

Our notice of assignment will inform you as the assigned operator (or related person) which beneficiaries have been assigned to you, the reason for the assignment, and the dates of employment on which the assignment was based. The notice will explain that, if you disagree with the assignment for any beneficiary listed in the notice of assignment, you may request from us detailed information as to the work history of the miner and the basis for the assignment. Such request must be filed with us within 30 days after you receive the notice of assignment, as explained in § 422.604. The notice will also explain that if you still disagree with the assignment after you have received the detailed information, you may submit evidence that shows there is a prima facie case of error in that assignment and request review. Such request must be filed with us within 30 days after you receive the detailed information, as explained in § 422.605. Alternatively, you may request review within 30 days after you receive the notice of assignment, even if you have not first requested the detailed information. In that case, you still may request the detailed information within that 30-day period. (See § 422.606(c) for further details.)

§ 422.604 Request for detailed information.

(a) *General.* After you receive our notice of assignment listing the beneficiaries for whom you have premium responsibility, you may request detailed information as to the work histories of any of the listed miners and the basis for the assignment. Your request for detailed information must:

(1) Be in writing;

(2) Be filed with us within 30 days of receipt of that notice of assignment. Unless you submit evidence showing a later receipt of the notice, we will assume the notice was received by you within 5 days of the date appearing on the notice. We will consider the request to be filed as of the date we receive it. However, if we receive the request after the 30-day period, the postmark date on the envelope may be used as the filing date. If there is no postmark or the postmark is illegible, the filing date will be deemed to be the fifth day prior to the day we received the request; and

(3) Identify the individual miners about whom you are requesting the detailed information.

(b) *The detailed information we will provide.* We will send you detailed information as to the work history and

the basis for the assignment for each miner about whom you requested such information. This information will include the name and address of each employer for whom the miner has worked since 1978 or since 1946 (whichever period is appropriate), the amount of wages paid by each employer and the period for which the wages were reported. We will send you the detailed information with a notice informing you that you have 30 days from the date you receive the information to submit to SSA evidence of a prima facie case of error (as defined in § 422.602) and request review of the assignment if you have not already requested review. The notice will also inform you that, if you are seeking evidence to make a case of prima facie error, you may include with a timely filed request for review a written request for additional time to obtain and submit such evidence to us. Under these circumstances, you will have 90 days from the date of your request to submit the evidence before we determine whether we will review the assignment.

§ 422.605 Request for review.

We will review an assignment if you request review and show that there is a prima facie case of error regarding the assignment. This review is a review on the record and will not entail a face-to-face hearing. We will review an assignment if:

(a) You are an assigned operator (or related person);

(b) Your request is in writing and states your reasons for believing the assignment is erroneous;

(c) Your request is filed with us no later than 30 days from the date you received the detailed information described in § 422.604, or no later than 30 days from the date you received the notice of assignment if you choose not to request detailed information. Unless you submit evidence showing a later receipt of the notice, we will assume you received the detailed information or the notice of assignment within 5 days of the date shown thereon. We will consider the request to be filed as of the date we receive it. However, if we receive the request after the 30-day period, the postmark date on the envelope may be used as the filing date. If there is no postmark or the postmark is illegible, the filing date will be deemed to be the fifth day prior to the day we received the request; and

(d) Your request is accompanied by evidence establishing a prima facie case of error regarding the assignment. If your request for review includes a request for additional time to submit such evidence, we will give you an additional 90 days from the date of your request for review to submit such evidence to us.

§ 422.606 Processing the request for review.

Upon receipt of your written request for review of an assignment and where relevant, the expiration of any additional times allowed under §§ 422.605(d) and 422.606(c), we will take the following action:

(a) *Request not timely filed.* If your request is not filed within the time limits set out in § 422.605(c), we will deny your request for review on that basis and send you a notice explaining that we have taken this action;

(b) *Lack of evidence.* If your request is timely filed under § 422.605(c) but you have not provided evidence constituting a prima facie case of error, we will deny your request for review on that basis and send you a notice explaining that we have taken this action;

(c) *Request for review without requesting detailed information.* If your request is filed within 30 days after you received the notice of assignment and you have not requested detailed information, we will not process your request until at least 30 days after the date you received the notice of assignment. You may still request detailed information within that 30-day period, in which case we will not process your request for review until at least 30 days after you received the detailed information, so that you may submit additional evidence if you wish;

(d) *Reviewing the evidence.* If your request meets the filing requirements of § 422.605 and is accompanied by evidence constituting a prima facie case of error, we will review the assignment. We will review all evidence submitted with your request for review, together

with the evidence used in making the assignment. An SSA employee who was not involved in the original assignment will perform the review. The review will be a review on the record and will not involve a face-to-face hearing.

(e) *Original decision correct.* If, following this review of the evidence you have submitted and the evidence in our file, we make a determination that the assignment is correct, we will send you a notice explaining the basis for our decision. We will not review the decision again, except as provided in § 422.607.

(f) *Original decision erroneous.* If, following this review of the evidence you have submitted and the evidence in our file, we make a determination that the assignment is erroneous, we will send you a notice to this effect. We will then determine who the correct operator is and assign the affected beneficiary(s) to that coal operator (or related person). If no assigned operator can be identified, the affected beneficiary(s) will be treated as ''unassigned.'' We will notify the UMWA Combined Benefit Fund Trustees of the review decision so that any premium liability of the initial assigned operator can be adjusted.

§ 422.607 Limited reopening of assignments.

On our own initiative, we may reopen and revise an assignment, whether or not it has been reviewed as described in this subpart, under the following conditions:

(a) The assignment reflects an error on the face of our records or the assignment was based upon fraud; and

(b) We sent to the assigned operator (or related person) notice of the assignment within 12 months of the time we decided to reopen that assignment.

Subpart H—Use of SSA Telephone Lines

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

SOURCE: 63 FR 57058, Oct. 26, 1998, unless otherwise noted.

§ 422.701 Scope and purpose.

The regulations in this subpart describe the limited circumstances under which SSA is authorized to listen-in to or record telephone conversations. The purpose of this subpart is to inform the public and SSA employees of those circumstances and the procedures that SSA will follow when conducting telephone service observation activities.

§ 422.705 When SSA employees may listen-in to or record telephone conversations.

SSA employees may listen-in to or record telephone conversations on SSA telephone lines under the following conditions:

(a) *Law enforcement/national security.* When performed for law enforcement, foreign intelligence, counterintelligence or communications security purposes when determined necessary by the Commissioner of Social Security or designee. Such determinations shall be in writing and shall be made in accordance with applicable laws, regulations and Executive Orders governing such activities. Communications security monitoring shall be conducted in accordance with procedures approved by the Attorney General. Line identification equipment may be installed on SSA telephone lines to assist Federal law enforcement officials in investigating threatening telephone calls, bomb threats and other criminal activities.

(b) *Public safety.* When performed by an SSA employee for public safety purposes and when documented by a written determination by the Commissioner of Social Security or designee citing the public safety needs. The determination shall identify the segment of the public needing protection and cite examples of the possible harm from which the public requires protection. Use of SSA telephone lines identified for reporting emergency and other public safety-related situations will be deemed as consent to public safety monitoring and recording. (See § 422.710(a)(1))

(c) *Public service monitoring.* When performed by an SSA employee after the Commissioner of Social Security or designee determines in writing that monitoring of such lines is necessary

for the purposes of measuring or monitoring SSA's performance in the delivery of service to the public; or monitoring and improving the integrity, quality and utility of service provided to the public. Such monitoring will occur only on telephone lines used by employees to provide SSA-related information and services to the public. Use of such telephone lines will be deemed as consent to public service monitoring. (See § 422.710(a)(2) and (c)).

(d) *All-party consent.* When performed by an SSA employee with the prior consent of all parties for a specific instance. This includes telephone conferences, secretarial recordings and other administrative practices. The failure to identify all individuals listening to a conversation by speaker phone is not prohibited by this or any other section.

§ 422.710 Procedures SSA will follow.

SSA component(s) that plan to listen-in to or record telephone conversations under § 422.705(b) or (c) shall comply with the following procedures.

(a) Prepare a written certification of need to the Commissioner of Social Security or designee at least 30 days before the planned operational date. A certification as used in this section means a written justification signed by the Deputy Commissioner of the requesting SSA component or designee, that specifies general information on the following: the operational need for listening-in to or recording telephone conversations; the telephone lines and locations where monitoring is to be performed; the position titles (or a statement about the types) of SSA employees involved in the listening-in to or recording of telephone conversations; the general operating times and an expiration date for the monitoring. This certification of need must identify the telephone lines which will be subject to monitoring, e.g., SSA 800 number voice and text telephone lines, and include current copies of any documentation, analyses, determinations, policies and procedures supporting the application, and the name and telephone number of a contact person in the SSA component which is requesting authority to listen-in to or record telephone conversations.

(1) When the request involves listening-in to or recording telephone conversations for public safety purposes, the requesting component head or designee must identify the segment of the public needing protection and cite examples of the possible harm from which the public requires protection.

(2) When the request involves listening-in to or recording telephone conversations for public service monitoring purposes, the requesting component head or designee must provide a statement in writing why such monitoring is necessary for measuring or monitoring the performance in the delivery of SSA service to the public; or monitoring and improving the integrity, quality and utility of service provided to the public.

(b) At least every 5 years, SSA will review the need for each determination authorizing listening-in or recording activities in the agency. SSA components or authorized agents involved in conducting listening-in or recording activities must submit documentation as described in § 422.710(a) to the Commissioner of Social Security or a designee to continue or terminate telephone service observation activities.

(c) SSA will comply with the following controls, policies and procedures when listening-in or recording is associated with public service monitoring.

(1) SSA will provide a message on SSA telephone lines subject to public service monitoring that will inform callers that calls on those lines may be monitored for quality assurance purposes. SSA will also continue to include information about telephone monitoring activities in SSA brochures and/or pamphlets as notification that some incoming and outgoing SSA telephone calls are monitored to ensure SSA's clients are receiving accurate and courteous service.

(2) SSA employees authorized to listen-in to or record telephone calls are permitted to annotate personal identifying information about the calls, such as a person's name, Social Security number, address and/or telephone number. When this information is obtained from public service monitoring as defined in § 422.705(c), it will be used for programmatic or policy purposes; e.g.,

recontacting individuals to correct or supplement information relating to benefits, for assessment of current/proposed policies and procedures, or to correct SSA records. Privacy Act requirements must be followed if data are retrievable by personal identifying information.

(3) SSA will take appropriate corrective action, when possible, if information obtained from monitoring indicates SSA may have taken an incorrect action which could affect the payment of or eligibility to SSA benefits.

(4) Telephone instruments subject to public service monitoring will be conspicuously labeled.

(5) Consent from both parties is needed to tape record SSA calls for public service monitoring purposes.

(d) The recordings and records pertaining to the listening-in to or recording of any conversations covered by this subpart shall be used, safeguarded and destroyed in accordance with SSA records management program.

PART 423—SERVICE OF PROCESS

Sec.

423.1 Suits against the Social Security Administration and its employees in their official capacities.
423.3 Other process directed to the Social Security Administration or the Commissioner.
423.5 Process against Social Security Administration officials in their individual capacities.
423.7 Acknowledgment of mailed process.
423.9 Effect of regulations in this part.

AUTHORITY: Sec. 701 and 702(a)(5) of the Social Security Act (42 U.S.C. 901 and 902(a)(5)).

SOURCE: 60 FR 18992, Apr. 14, 1995, unless otherwise noted.

§423.1 Suits against the Social Security Administration and its employees in their official capacities.

Summonses and complaints to be served by mail on the Social Security Administration, the Commissioner of Social Security, or other employees of the Social Security Administration in their official capacities should be sent to the General Counsel, Social Security Administration, Room 611, Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235.

§423.3 Other process directed to the Social Security Administration or the Commissioner.

Subpoenas and other process (other than summonses and complaints) that are required to be served on the Social Security Administration or the Commissioner of Social Security in his or her official capacity should be served as follows:

(a) If authorized by law to be served by mail, any mailed process should be sent to the General Counsel, Social Security Administration, Room 611, Altmeyer Building, 6401 Security Boulevard, Baltimore, MD 21235.

(b) If served by an individual, the process should be delivered to the mail room staff in the Office of the General Counsel, Room 611, 6401 Security Blvd., Baltimore, MD 21235 or, in the absence of that staff, to any Deputy General Counsel or secretary to any Deputy General Counsel of the Social Security Administration.

§423.5 Process against Social Security Administration officials in their individual capacities.

Process to be served on Social Security Administration officials in their individual capacities must be served in compliance with the requirements for service of process on individuals who are not governmental officials. The Office of the General Counsel is authorized but not required to accept process to be served on Social Security Administration officials in their individual capacities if the suit relates to an employee's official duties.

§423.7 Acknowledgment of mailed process.

The Social Security Administration will not provide a receipt or other acknowledgment of process received, except for a return receipt associated with certified mail and, where required, the acknowledgment described in rule 4(e) of the Federal Rules of Civil Procedure (28 U.S.C. App. 4(e)).

§423.9 Effect of regulations in this part.

The regulations in this part are intended solely to identify Social Security Administration officials who are authorized to accept service of process.

Litigants must comply with all requirements pertaining to service of process that are established by statute and court rule even though they are not repeated in this part.

PARTS 424–428 [RESERVED]

PART 429—ADMINISTRATIVE REGULATIONS

TORT CLAIMS AGAINST THE GOVERNMENT

Sec.
429.101 Scope of regulations.
429.102 Administrative claims; when presented; place of filing.
429.103 Administrative claims; who may file.
429.104 Administrative claims; evidence and information to be submitted.
429.105 Investigation, examination, and determination of claims.
429.106 Final denial of claims.
429.107 Payment of approved claims.
429.108 Release.
429.109 Penalties.
429.110 Limitation on SSA's authority.

AUTHORITY: Sec. 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)), 28 U.S.C. 2672; 28 CFR part 14.

SOURCE: 62 FR 24329, May 2, 1997, unless otherwise noted.

TORT CLAIMS AGAINST THE GOVERNMENT

§ 429.101 Scope of regulations.

The regulations in this part shall apply only to claims asserted under the Federal Tort Claims Act, as amended, 28 U.S.C. sections 2671–2680, for money damages against the United States for damage to or loss of property or personal injury or death caused by the negligent or wrongful act or omission of any employee of the Social Security Administration (SSA) while acting within the scope of his office or employment.

§ 429.102 Administrative claims; when presented; place of filing.

(a) For purposes of the regulations in this part, a claim shall be deemed to have been presented when SSA receives, at a place designated in paragraph (c) of this section, an executed Standard Form 95 or other written notification of an incident accompanied by a claim for money damages in a sum certain for damage to or loss of property, for personal injury, or for death, alleged to have occurred by reason of the incident. A claim which should have been presented to SSA but which was mistakenly addressed to or filed with another Federal agency, shall be deemed to be presented to SSA as of the date that the claim is received by SSA. A claim mistakenly addressed to or filed with SSA shall forthwith be transferred to the appropriate Federal agency, if ascertainable, or returned to the claimant.

(b) A claim presented in compliance with paragraph (a) of this section may be amended by the claimant at any time prior to final action by the SSA Claims Officer or prior to the exercise of the claimant's option to bring suit under 28 U.S.C. 2675(a). Amendments shall be submitted in writing and signed by the claimant. Upon the timely filing of an amendment to a pending claim, SSA shall have 6 months in which to make a final disposition of the claim as amended and the claimant's option under 28 U.S.C. 2675(a) shall not accrue until 6 months after the filing of an amendment.

(c) Forms may be obtained from and claims may be filed with the SSA Claims Officer, Room 611, Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

§ 429.103 Administrative claims; who may file.

(a) A claim for injury to or loss of property may be presented by the owner of the property interest which is the subject of the claim, his duly authorized agent, or his legal representative.

(b) A claim for personal injury may be presented by the injured person, his duly authorized agent, or his legal representative.

(c) A claim based on death may be presented by the executor or administrator of the decedent's estate or by any other person legally entitled to assert such a claim under applicable state law.

(d) A claim for loss wholly compensated by an insurer with the rights of a subrogee may be presented by the insurer. A claim for loss partially compensated by an insurer with the rights of a subrogee may be presented by the

insurer or the insured individually, as their respective interests appear, or jointly. Whenever an insurer presents a claim asserting the rights of a subrogee, he shall present with his claim appropriate evidence that he has the rights of a subrogee.

(e) A claim presented by an agent or legal representative shall be presented in the name of the claimant, be signed by the agent or legal representative, show the title or legal capacity of the person signing, and be accompanied by evidence of his authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian, or other representative.

§ 429.104 Administrative claims; evidence and information to be submitted.

(a) *Death.* In support of a claim based on death, the claimant may be required to submit the following evidence or information:

(1) An authenticated death certificate or other competent evidence showing cause of death, date of death, and age of the decedent.

(2) Decedent's employment or occupation at time of death, including his monthly or yearly salary or earnings (if any), and the duration of his last employment or occupation.

(3) Full names, addresses, birth dates, kinship, and marital status of the decedent's survivors, including identification of those survivors who were dependent for support upon the decedent at the time of his death.

(4) Degree of support afforded by the decedent to each survivor dependent upon him for support at the time of his death.

(5) Decedent's general physical and mental condition before death.

(6) Itemized bills for medical and burial expenses incurred by reason of the incident causing death, or itemized receipts of payments for such expenses.

(7) If damages for pain and suffering prior to death are claimed, a physician's detailed statement specifying the injuries suffered, duration of pain and suffering, any drugs administered for pain and the decedent's physical condition in the interval between injury and death.

(8) Any other evidence or information which may have a bearing on either the responsibility of the United States for the death or the damages claimed.

(b) *Personal injury.* In support of a claim for personal injury, including pain and suffering, the claimant may be required to submit the following evidence or information:

(1) A written report by his attending physician or dentist setting forth the nature and extent of the injury, nature and extent of treatment, any degree of temporary or permanent disability, the prognosis, period of hospitalization, and any diminished earning capacity. In addition, the claimant may be required to submit to a physical or mental examination by a physician employed or designated by SSA. A copy of the report of the examining physician shall be made available to the claimant upon the claimant's written request provided that claimant has, upon request, furnished the report referred to in the first sentence of this paragraph (b)(1) and has made or agrees to make available to SSA any other physician's reports previously or thereafter made of the physical or mental condition which is the subject matter of his claim.

(2) Itemized bills for medical, dental, and hospital expenses incurred, or itemized receipts of payment for such expenses.

(3) If the prognosis reveals the necessity for future treatment, a statement of expected duration of and expenses for such treatment.

(4) If a claim is made for loss of time from employment, a written statement from his employer showing actual time lost from employment, whether he is a full or part-time employee, and wages or salary actually lost.

(5) If a claim is made for loss of income and the claimant is self-employed, documentary evidence showing the amount of earnings actually lost.

(6) Any other evidence or information which may have a bearing on either the responsibility of the United States for the personal injury or the damages claimed.

(c) *Property damage.* In support of a claim for damage to or loss of property, real or personal, the claimant may be

required to submit the following evidence or information:

(1) Proof of ownership.

(2) A detailed statement of the amount claimed with respect to each item of property.

(3) An itemized receipt of payment for necessary repairs or itemized written estimates of the cost of such repairs.

(4) A statement listing date of purchase, purchase price, market value of the property as of date of damage, and salvage value, where repair is not economical.

(5) Any other evidence or information which may have a bearing either on the responsibility of the United States for the injury to or loss of property or the damages claimed.

(d) *Time limit.* All evidence required to be submitted by this section shall be furnished by the claimant within a reasonable time. Failure of a claimant to furnish evidence necessary to a determination of his claim within three months after a request therefor has been mailed to his last known address may be deemed an abandonment of the claim. The claim may be thereupon disallowed.

§ 429.105 Investigation, examination, and determination of claims.

When a claim is received, SSA shall make such investigation as may be necessary or appropriate for a determination of the validity of the claim and thereafter shall forward the claim, together with all pertinent material, and a recommendation based on the merits of the case, with regard to allowance or disallowance of the claim, to the SSA Claims Officer to whom authority has been delegated to adjust, determine, compromise and settle all claims hereunder.

§ 429.106 Final denial of claims.

(a) Final denial of an administrative claim shall be in writing and sent to the claimant, his attorney, or legal representative by certified or registered mail. The notification of final denial may include a statement of the reasons for the denial and shall include a statement that, if the claimant is dissatisfied with SSA's action, he may file suit in an appropriate U.S. District Court not later than 6 months after the date of mailing of the notification.

(b) Prior to the commencement of suit and prior to the expiration of the 6-month period after the date of mailing, by certified or registered mail of notice of final denial of the claim as provided in 28 U.S.C. 2401(b), a claimant, his duly authorized agent, or legal representative, may file a written request with SSA for reconsideration of a final denial of a claim under paragraph (a) of this section. Upon the timely filing of a request for reconsideration SSA shall have 6 months from the date of filing in which to make a final disposition of the claim and the claimant's option under 28 U.S.C. 2675(a) to bring suit shall not accrue until 6 months after the filing of a request for reconsideration. Final SSA action on a request for reconsideration shall be effected in accordance with the provisions of paragraph (a) of this section.

§ 429.107 Payment of approved claims.

(a) Upon allowance of his claim, claimant or his duly authorized agent shall sign the voucher for payment, Standard Form 1145, before payment is made.

(b) When the claimant is represented by an attorney, the voucher for payment (SF 1145) shall designate both the claimant and his attorney as ''payees.'' The check shall be delivered to the attorney whose address shall appear on the voucher.

§ 429.108 Release.

Acceptance by the claimant, his agent or legal representative, of any award, compromise or settlement made hereunder, shall be final and conclusive on the claimant, his agent or legal representative and any other person on whose behalf or for whose benefit the claim has been presented, and shall constitute a complete release of any claim against the United States and against any employee of the Government whose act or omission gave rise to the claim, by reason of the same subject matter.

§ 429.109 Penalties.

A person who files a false claim or makes a false or fraudulent statement in a claim against the United States

may be liable to a fine of not more than $10,000 or to imprisonment of not more than 5 years, or both (18 U.S.C. §§ 287; 1001), and, in addition, to a forfeiture of $2,000 and a penalty of double the loss or damage sustained by the United States (31 U.S.C. § 231).

§ 429.110 Limitation on SSA's authority.

(a) An award, compromise or settlement of a claim hereunder in excess of $25,000 shall be effected only with the prior written approval of the Attorney General or his designee. For the purposes of this paragraph, a principal claim and any derivative or subrogated claim shall be treated as a single claim.

(b) An administrative claim may be adjusted, determined, compromised or settled hereunder only after consultation with the Department of Justice when, in the opinion of SSA:

(1) A new precedent or a new point of law is involved; or

(2) A question of policy is or may be involved; or

(3) The United States is or may be entitled to indemnity or contribution from a third party and SSA is unable to adjust the third party claim; or

(4) The compromise of a particular claim, as a practical matter, will or may control the disposition of a related claim in which the amount to be paid may exceed $25,000.

(c) An administrative claim may be adjusted, determined, compromised or settled only after consultation with the Department of Justice when it is learned that the United States or an employee, agent or cost plus contractor of the United States is involved in litigation based on a claim arising out of the same incident or transaction.

PART 430—PERSONNEL

AUTHORITY: Section 702(a)(5) of the Social Security Act (42 U.S.C. 902(a)(5)).

INDEMNIFICATION OF SSA EMPLOYEES

§ 430.101 Policy.

(a) The Social Security Administration (SSA) may indemnify, in whole or in part, its employees (which for the purpose of this regulation includes former employees) for any verdict, judgment or other monetary award which is rendered against any such employee, provided that the conduct giving rise to the verdict, judgment or award was taken within the scope of his or her employment with SSA and that such indemnification is in the interest of the United States, as determined by the Commissioner, or his or her designee, in his or her discretion.

(b) SSA may settle or compromise a personal damage claim against its employee by the payment of available funds, at any time, provided the alleged conduct giving rise to the personal damage claim was taken within the scope of employment and that such settlement or compromise is in the interest of the United States, as determined by the Commissioner, or his or her designee, in his or her discretion.

(c) Absent exceptional circumstances, as determined by the Commissioner or his or her designee, SSA will not entertain a request either to agree to indemnify or to settle a personal damage claim before entry of an adverse verdict, judgment or monetary award.

(d) When an employee of SSA becomes aware that an action has been filed against the employee in his or her individual capacity as a result of conduct taken within the scope of his or her employment, the employee should immediately notify SSA that such an action is pending.

(e) The employee may, thereafter, request either:

(1) Indemnification to satisfy a verdict, judgment or award entered against the employee; or

(2) Payment to satisfy the requirements of a settlement proposal. The employee shall submit a written request, with documentation including copies of the verdict, judgment, award or settlement proposal, as appropriate, to the Deputy Commissioner or other designated official, who shall thereupon submit to the General Counsel, in a timely manner, a recommended disposition of the request. The General Counsel shall also seek the views of the Department of Justice. The General Counsel shall forward the request, the

Deputy Commissioner's or other designated official's recommended disposition, and the General Counsel's recommendation to the Commissioner or his or her designee for decision.

(f) Any payment under this section either to indemnify an SSA employee or to settle a personal damage claim shall be contingent upon the availability of appropriated funds.

[62 FR 39935, July 25, 1997]

PARTS 431–497 [RESERVED]

PART 498—CIVIL MONETARY PENALTIES, ASSESSMENTS AND RECOMMENDED EXCLUSIONS

Sec.
498.100 Basis and purpose.
498.101 Definitions.
498.102 Basis for civil monetary penalties and assessments.
498.103 Amount of penalty.
498.104 Amount of assessment.
498.105 [Reserved]
498.106 Determinations regarding the amount or scope of penalties and assessments.
498.107 [Reserved]
498.108 Penalty and assessment not exclusive.
498.109 Notice of proposed determination.
498.110 Failure to request a hearing.
498.114 Collateral estoppel.
498.115–498.125 [Reserved]
498.126 Settlement.
498.127 Judicial review.
498.128 Collection of penalty and assessment.
498.129 Notice to other agencies.
498.132 Limitations.
498.201 Definitions.
498.202 Hearing before an administrative law judge.
498.203 Rights of parties.
498.204 Authority of the administrative law judge.
498.205 Ex parte contacts.
498.206 Prehearing conferences.
498.207 Discovery.
498.208 Exchange of witness lists, witness statements and exhibits.
498.209 Subpoenas for attendance at hearing.
498.210 Fees.
498.211 Form, filing and service of papers.
498.212 Computation of time.
498.213 Motions.
498.214 Sanctions.
498.215 The hearing and burden of proof.
498.216 Witnesses.
498.217 Evidence.
498.218 The record.
498.219 Post-hearing briefs.
498.220 Initial decision.
498.221 Appeal to DAB.
498.222 Final decision of the Commissioner.
498.223 Stay of initial decision.
498.224 Harmless error.

AUTHORITY: Secs. 702(a)(5), 1129, and 1140 of the Social Security Act (42 U.S.C. 902(a)(5), 1320a–8, and 1320b–10).

SOURCE: 60 FR 58226, Nov. 27, 1995, unless otherwise noted.

§ 498.100 Basis and purpose.

(a) *Basis.* This part implements sections 1129 and 1140 of the Social Security Act (42 U.S.C. 1320a–8 and 1320b–10).

(b) *Purpose.* This part provides for the imposition of civil monetary penalties and assessments, as applicable, against persons who—

(1) Make or cause to be made false statements or representations, or omissions of material fact for use in determining any right to or amount of benefits under title II or benefits or payments under title XVI of the Social Security Act; or

(2) Misuse certain Social Security program words, letters, symbols, and emblems.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18079, Apr. 24, 1996]

§ 498.101 Definitions.

As used in this part:

Agency means the Social Security Administration.

Assessment means the amount described in § 498.104, and includes the plural of that term.

Commissioner means the Commissioner of Social Security or his or her designees.

Department means the U.S. Department of Health and Human Services.

General Counsel means the General Counsel of the Social Security Administration or his or her designees.

Inspector General means the Inspector General of the Social Security Administration or his or her designees.

Material fact means a fact which the Commissioner of Social Security may consider in evaluating whether an applicant is entitled to benefits under title II or eligible for benefits or payments under title XVI of the Social Security Act.

Penalty means the amount described in § 498.103 and includes the plural of that term.

Person means an individual, organization, agency, or other entity.

Respondent means the person upon whom the Commissioner or the Inspector General has imposed, or intends to impose, a penalty and assessment, as applicable.

Secretary means the Secretary of the U.S. Department of Health and Human Services or his or her designees.

SSA means the Social Security Administration.

SSI means Supplemental Security Income.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18079, Apr. 24, 1996]

§ 498.102 Basis for civil monetary penalties and assessments.

(a) The Office of the Inspector General may impose a penalty and assessment, as applicable, against any person whom it determines in accordance with this part—

(1) Has made, or caused to be made, a statement or representation of a material fact for use in determining any initial or continuing right to or amount of:

(i) Monthly insurance benefits under title II of the Social Security Act; or

(ii) Benefits or payments under title XVI of the Social Security Act; and

(2)(i) Knew, or should have known, that the statement or representation—

(A) Was false or misleading; or

(B) Omitted a material fact; or

(ii) Made such statement with knowing disregard for the truth.

(b) The Office of the Inspector General may impose a penalty against any person whom it determines in accordance with this part has made use of certain Social Security program words, letters, symbols, or emblems in such a manner that they knew or should have known would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that an advertisement or other item was authorized, approved, or endorsed by the Social Security Administration, or that such person has some connection with, or authorization from, the Social Security Administration.

(1) Civil monetary penalties may be imposed for misuse, as set forth in § 498.102(b), of—

(i) The words ''Social Security,'' ''Social Security Account,'' ''Social Security Administration,'' ''Social Security System,'' ''Supplemental Security Income Program,'' or any combination or variation of such words; or

(ii) The letters ''SSA,'' or ''SSI,'' or any other combination or variation of such letters; or

(iii) A symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the Social Security card, the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration), or any other combination or variation of such symbols or emblems.

(2) Civil monetary penalties will not be imposed against any agency or instrumentality of a State, or political subdivision of a State, that makes use of any symbol or emblem, or any words or letters which identify that agency or instrumentality of the State or political subdivision.

(c) The use of a disclaimer of affiliation with the United States Government, the Social Security Administration or its programs, or any other agency or instrumentality of the United States Government, will not be considered as a defense in determining a violation of section 1140 of the Social Security Act.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18079, Apr. 24, 1996]

§ 498.103 Amount of penalty.

(a) Under § 498.102(a), the Office of the Inspector General may impose a penalty of not more than $5,000 for each false statement or representation.

(b) Under section § 498.102(b), the Office of the Inspector General may impose a penalty of not more than $5,000 for each violation resulting from the misuse of Social Security Administration program words, letters, symbols, or emblems relating to printed media, and a penalty of not more than $25,000 in the case of such misuse related to a broadcast or telecast.

(c) For purposes of paragraph (b) of this section, a violation is defined as—

(1) In the case of a direct mailing solicitation or advertisement, each separate piece of mail which contains one or more program words, letters, symbols, or emblems related to a determination under § 498.102(b); and

(2) In the case of a broadcast or telecast, each airing of a single commercial or solicitation related to a determination under § 498.102(b).

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18080, Apr. 24, 1996]

§ 498.104 Amount of assessment.

A person subject to a penalty determined under § 498.102(a) may be subject, in addition, to an assessment of not more than twice the amount of benefits or payments paid as a result of the statement or representation which was the basis for the penalty. An assessment is in lieu of damages sustained by the United States because of such statement or representation.

[61 FR 18080, Apr. 24, 1996]

§ 498.105 [Reserved]

§ 498.106 Determinations regarding the amount or scope of penalties and assessments.

(a) In determining the amount or scope of any penalty and assessment, as applicable, in accordance with §§ 498.103(a) and 498.104, the Office of the Inspector General will take into account:

(1) The nature of the statements and representations referred to in § 498.102(a) and the circumstances under which they occurred;

(2) The degree of culpability of the person committing the offense;

(3) The history of prior offenses of the person committing the offense;

(4) The financial condition of the person committing the offense; and

(5) Such other matters as justice may require.

(b) In determining the amount of any penalty in accordance with § 498.103(b), the Office of the Inspector General will take into account—

(1) The nature and objective of the advertisement, solicitation, or other communication, and the circumstances under which they were presented;

(2) The frequency and scope of the violation, and whether a specific segment of the population was targeted;

(3) The prior history of the individual, organization, or entity in their willingness or refusal to comply with informal requests to correct violations;

(4) The history of prior offenses of the individual, organization, or entity in their misuse of program words, letters, symbols, and emblems;

(5) The financial condition of the individual or entity; and

(6) Such other matters as justice may require.

(c) In cases brought under section 1140 of the Social Security Act, the use of a disclaimer of affiliation with the United States Government, the Social Security Administration or its programs will not be considered as a mitigating factor in determining the amount of a penalty in accordance with § 498.106.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18080, Apr. 24, 1996]

§ 498.107 [Reserved]

§ 498.108 Penalty and assessment not exclusive.

Penalties and assessments, as applicable, imposed under this part are in addition to any other penalties prescribed by law.

[61 FR 18080, Apr. 24, 1996]

§ 498.109 Notice of proposed determination.

(a) If the Office of the Inspector General seeks to impose a penalty and assessment, as applicable, it will serve written notice of the intent to take such action. The notice will include:

(1) Reference to the statutory basis for the proposed penalty and assessment, as applicable;

(2) A description of the false statements, representations, and incidents, as applicable, with respect to which the penalty and assessment, as applicable, are proposed;

(3) The amount of the proposed penalty and assessment, as applicable;

(4) Any circumstances described in § 498.106 that were considered when determining the amount of the proposed penalty and assessment, as applicable; and

(5) Instructions for responding to the notice, including

(i) A specific statement of respondent's right to a hearing; and

(ii) A statement that failure to request a hearing within 60 days permits the imposition of the proposed penalty and assessment, as applicable, without right of appeal.

(b) Any person upon whom the Office of the Inspector General has proposed the imposition of a penalty and assessment, as applicable, may request a hearing on such proposed penalty and assessment.

(c) If the respondent fails to exercise the respondent's right to a hearing within the time permitted under this section, and does not demonstrate good cause for such failure before an administrative law judge, any penalty and assessment, as applicable, becomes final.

[61 FR 18080, Apr. 24, 1996]

§ 498.110 Failure to request a hearing.

If the respondent does not request a hearing within the time prescribed by § 498.109(a), the Office of the Inspector General may seek the proposed penalty and assessment, as applicable, or any less severe penalty and assessment. The Office of the Inspector General shall notify the respondent by certified mail, return receipt requested, of any penalty and assessment, as applicable, that has been imposed and of the means by which the respondent may satisfy the amount owed.

[61 FR 18080, Apr. 24, 1996]

§ 498.114 Collateral estoppel.

In a proceeding under section 1129 of the Social Security Act that—

(a) Is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal or State crime charging fraud or false statements; and

(b) Involves the same transactions as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.

[61 FR 18080, Apr. 24, 1996]

§§ 498.115–498.125 [Reserved]

§ 498.126 Settlement.

The Inspector General has exclusive authority to settle any issues or case, without the consent of the administrative law judge or the Commissioner, at any time prior to a final determination. Thereafter, the Commissioner or his or her designee has such exclusive authority.

§ 498.127 Judicial review.

Sections 1129 and 1140 of the Social Security Act authorize judicial review of any penalty and assessment, as applicable, that has become final. Judicial review may be sought by a respondent only in regard to a penalty and assessment, as applicable, with respect to which the respondent requested a hearing, unless the failure or neglect to urge such objection is excused by the court because of extraordinary circumstances.

[61 FR 18080, Apr. 24, 1996]

§ 498.128 Collection of penalty and assessment.

(a) Once a determination has become final, collection of any penalty and assessment, as applicable, will be the responsibility of the Commissioner or his or her designee.

(b) In cases brought under section 1129 of the Social Security Act, a penalty and assessment, as applicable, imposed under this part may be compromised by the Commissioner or his or her designee, and may be recovered in a civil action brought in the United States District Court for the district where the statement or representation referred to in § 498.102(a) was made, or where the respondent resides.

(c) In cases brought under section 1140 of the Social Security Act, a penalty imposed under this part may be compromised by the Commissioner or his or her designee and may be recovered in a civil action brought in the United States district court for the district where, as determined by the Commissioner, the:

(1) Violation referred to in § 498.102(b) occurred; or

(2) Respondent resides; or

(3) Respondent has its principal office; or

(4) Respondent may be found.

(d) As specifically provided under the Social Security Act, in cases brought under section 1129 of the Social Security Act, the amount of a penalty and assessment, as applicable, when finally determined, or the amount agreed upon in compromise, may also be deducted from:

(1) Monthly title II or title XVI payments, notwithstanding section 207 of the Social Security Act as made applicable to title XVI by section 1631(d)(1) of the Social Security Act;

(2) A tax refund to which a person is entitled to after notice to the Secretary of the Treasury under 31 U.S.C. § 3720A;

(3) By authorities provided under the Debt Collection Act of 1982, as amended, 31 U.S.C. 3711, to the extent applicable to debts arising under the Social Security Act; or

(4) Any combination of the foregoing.

(e) Matters that were raised or that could have been raised in a hearing before an administrative law judge or in an appeal to the United States Court of Appeals under sections 1129 or 1140 of the Social Security Act may not be raised as a defense in a civil action by the United States to collect a penalty and assessment, as applicable, under this part.

[60 FR 58226, Nov. 27, 1995, as amended at 61 FR 18080, Apr. 24, 1996]

§ 498.129 Notice to other agencies.

As provided in section 1129 of the Social Security Act, when a determination to impose a penalty and assessment, as applicable, with respect to a physician or medical provider becomes final, the Office of the Inspector General will notify the Secretary of the final determination and the reasons therefore.

[61 FR 18081, Apr. 24, 1996]

§ 498.132 Limitations.

The Office of the Inspector General may initiate a proceeding in accordance with § 498.109(a) to determine whether to impose a penalty and assessment, as applicable—

(a) In cases brought under section 1129 of the Social Security Act, after receiving authorization from the Attorney General pursuant to procedures agreed upon by the Inspector General and the Attorney General; and

(b) Within 6 years from the date on which the violation was committed.

[61 FR 18081, Apr. 24, 1996]

§ 498.201 Definitions.

As used in this part—

ALJ refers to an Administrative Law Judge of the Departmental Appeals Board.

Civil monetary penalty cases refer to all proceedings arising under any of the statutory bases for which the Inspector General, Social Security Administration has been delegated authority to impose civil monetary penalties.

DAB refers to the Departmental Appeals Board of the U.S. Department of Health and Human Services.

[61 FR 65468, Dec. 13, 1996]

§ 498.202 Hearing before an administrative law judge.

(a) A party sanctioned under any criteria specified in §§ 498.100 through 498.132 may request a hearing before an ALJ.

(b) In civil monetary penalty cases, the parties to a hearing will consist of the respondent and the Inspector General.

(c) The request for a hearing must be:

(1) In writing and signed by the respondent or by the respondent's attorney; and

(2) Filed within 60 days after the notice, provided in accordance with § 498.109, is received by the respondent or upon a showing of good cause, the time permitted by an ALJ.

(d) The request for a hearing shall contain a statement as to the:

(1) Specific issues or findings of fact and conclusions of law in the notice letter with which the respondent disagrees; and

(2) Basis for the respondent's contention that the specific issues or findings and conclusions were incorrect.

(e) For purposes of this section, the date of receipt of the notice letter will be presumed to be five days after the

date of such notice, unless there is a reasonable showing to the contrary.

(f) The ALJ shall dismiss a hearing request where:

(1) The respondent's hearing request is not filed in a timely manner and the respondent fails to demonstrate good cause for such failure;

(2) The respondent withdraws or abandons respondent's request for a hearing; or

(3) The respondent's hearing request fails to raise any issue which may properly be addressed in a hearing under this part.

[61 FR 65468, Dec. 13, 1996]

§ 498.203 Rights of parties.

(a) Except as otherwise limited by this part, all parties may:

(1) Be accompanied, represented, and advised by an attorney;

(2) Participate in any conference held by the ALJ;

(3) Conduct discovery of documents as permitted by this part;

(4) Agree to stipulations of fact or law which will be made part of the record;

(5) Present evidence relevant to the issues at the hearing;

(6) Present and cross-examine witnesses;

(7) Present oral arguments at the hearing as permitted by the ALJ; and

(8) Submit written briefs and proposed findings of fact and conclusions of law after the hearing.

(b) Fees for any services performed on behalf of a party by an attorney are not subject to the provisions of section 206 of title II of the Social Security Act, which authorizes the Commissioner to specify or limit these fees.

[61 FR 65469, Dec. 13, 1996]

§ 498.204 Authority of the administrative law judge.

(a) The ALJ will conduct a fair and impartial hearing, avoid delay, maintain order and assure that a record of the proceeding is made.

(b) The ALJ has the authority to:

(1) Set and change the date, time, and place of the hearing upon reasonable notice to the parties;

(2) Continue or recess the hearing in whole or in part for a reasonable period of time;

(3) Hold conferences to identify or simplify the issues, or to consider other matters that may aid in the expeditious disposition of the proceeding;

(4) Administer oaths and affirmations;

(5) Issue subpoenas requiring the attendance of witnesses at hearings and the production of documents at or in relation to hearings;

(6) Rule on motions and other procedural matters;

(7) Regulate the scope and timing of documentary discovery as permitted by this part;

(8) Regulate the course of the hearing and the conduct of representatives, parties, and witnesses;

(9) Examine witnesses;

(10) Receive, exclude, or limit evidence;

(11) Take official notice of facts;

(12) Upon motion of a party, decide cases, in whole or in part, by summary judgment where there is no disputed issue of material fact; and

(13) Conduct any conference or argument in person, or by telephone upon agreement of the parties.

(c) The ALJ does not have the authority to:

(1) Find invalid or refuse to follow Federal statutes or regulations, or delegations of authority from the Commissioner;

(2) Enter an order in the nature of a directed verdict;

(3) Compel settlement negotiations;

(4) Enjoin any act of the Commissioner or the Inspector General; or

(5) Review the exercise of discretion by the Office of the Inspector General to seek to impose a civil monetary penalty or assessment under §§ 498.100 through 498.132.

[61 FR 65469, Dec. 13, 1996]

§ 498.205 Ex parte contacts.

No party or person (except employees of the ALJ's office) will communicate in any way with the ALJ on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking

routine questions concerning administrative functions or procedures.

[61 FR 65469, Dec. 13, 1996]

§ 498.206 Prehearing conferences.

(a) The ALJ will schedule at least one prehearing conference, and may schedule additional prehearing conferences as appropriate, upon reasonable notice to the parties.

(b) The ALJ may use prehearing conferences to address the following:

(1) Simplification of the issues;

(2) The necessity or desirability of amendments to the pleadings, including the need for a more definite statement;

(3) Stipulations and admissions of fact as to the contents and authenticity of documents and deadlines for challenges, if any, to the authenticity of documents;

(4) Whether the parties can agree to submission of the case on a stipulated record;

(5) Whether a party chooses to waive appearance at a hearing and to submit only documentary evidence (subject to the objection of other parties) and written argument;

(6) Limitation of the number of witnesses;

(7) The time and place for the hearing and dates for the exchange of witness lists and of proposed exhibits;

(8) Discovery of documents as permitted by this part;

(9) Such other matters as may tend to encourage the fair, just, and expeditious disposition of the proceedings; and

(10) Potential settlement of the case.

(c) The ALJ shall issue an order containing the matters agreed upon by the parties or ordered by the ALJ at a prehearing conference.

[61 FR 65469, Dec. 13, 1996]

§ 498.207 Discovery.

(a) For the purpose of inspection and copying, a party may make a request to another party for production of documents which are relevant and material to the issues before the ALJ.

(b) Any form of discovery other than that permitted under paragraph (a) of this section, such as requests for admissions, written interrogatories and depositions, is not authorized.

(c) For the purpose of this section, the term documents includes information, reports, answers, records, accounts, papers, memos, notes and other data and documentary evidence. Nothing contained in this section will be interpreted to require the creation of a document, except that requested data stored in an electronic data storage system will be produced in a form accessible to the requesting party.

(d)(1) A party who has been served with a request for production of documents may file a motion for a protective order. The motion for protective order shall describe the document or class of documents to be protected, specify which of the grounds in § 498.207(d)(2) are being asserted, and explain how those grounds apply.

(2) The ALJ may grant a motion for a protective order if he or she finds that the discovery sought:

(i) Is unduly costly or burdensome;

(ii) Will unduly delay the proceeding; or

(iii) Seeks privileged information.

(3) The burden of showing that discovery should be allowed is on the party seeking discovery.

[61 FR 65469, Dec. 13, 1996]

§ 498.208 Exchange of witness lists, witness statements and exhibits.

(a) At least 15 days before the hearing, the parties shall exchange:

(1) Witness lists;

(2) Copies of prior written statements of proposed witnesses; and

(3) Copies of proposed hearing exhibits, including copies of any written statements that the party intends to offer in lieu of live testimony in accordance with § 498.216.

(b)(1) Failure to comply with the requirements of paragraph (a) of this section may result in the exclusion of evidence or testimony upon the objection of the opposing party.

(2) When an objection is entered, the ALJ shall determine whether good cause justified the failure to timely exchange the information listed under paragraph (a) of this section. If good cause is not found, the ALJ shall exclude from the party's case-in-chief:

(i) The testimony of any witness whose name does not appear on the witness list; and

(ii) Any exhibit not provided to the opposing party as specified in paragraph (a) of this section.

(3) If the ALJ finds that good cause exists, the ALJ shall determine whether the admission of such evidence would cause substantial prejudice to the objecting party due to the failure to comply with paragraph (a) of this section. If the ALJ finds no substantial prejudice, the evidence may be admitted. If the ALJ finds substantial prejudice, the ALJ may exclude the evidence, or at his or her discretion, may postpone the hearing for such time as is necessary for the objecting party to prepare and respond to the evidence.

(c) Unless a party objects by the deadline set by the ALJ's prehearing order pursuant to § 498.206 (b)(3) and (c), documents exchanged in accordance with paragraph (a) of this section will be deemed authentic for the purpose of admissibility at the hearing.

[61 FR 65470, Dec. 13, 1996]

§ 498.209 Subpoenas for attendance at hearing.

(a) A party wishing to procure the appearance and testimony of any individual, whose appearance and testimony are relevant and material to the presentation of a party's case at a hearing, may make a motion requesting the ALJ to issue a subpoena.

(b) A subpoena requiring the attendance of an individual may also require the individual (whether or not the individual is a party) to produce evidence at the hearing in accordance with § 498.207.

(c) A party seeking a subpoena will file a written motion not less than 30 days before the date fixed for the hearing, unless otherwise allowed by the ALJ for good cause shown. Such request will:

(1) Specify any evidence to be produced;

(2) Designate the witness(es); and

(3) Describe the address and location with sufficient particularity to permit such witness(es) to be found.

(d) Within 20 days after the written motion requesting issuance of a subpoena is served, any party may file an opposition or other response.

(e) If the motion requesting issuance of a subpoena is granted, the party seeking the subpoena will serve the subpoena by delivery to the individual named, or by certified mail addressed to such individual at his or her last dwelling place or principal place of business.

(f) The subpoena will specify the time and place at which the witness is to appear and any evidence the witness is to produce.

(g) The individual to whom the subpoena is directed may file with the ALJ a motion to quash the subpoena within 10 days after service.

(h) When a subpoena is served by a respondent on a particular individual or particular office of the Office of the Inspector General, the OIG may comply by designating any of its representatives to appear and testify.

(i) In the case of contumacy by, or refusal to obey a subpoena duly served upon any person, the exclusive remedy is specified in section 205(e) of the Social Security Act (42 U.S.C. 405(e)).

[61 FR 65470, Dec. 13, 1996]

§ 498.210 Fees.

The party requesting a subpoena will pay the cost of the fees and mileage of any witness subpoenaed in the amounts that would be payable to a witness in a proceeding in United States District Court. A check for witness fees and mileage will accompany the subpoena when served, except that when a subpoena is issued on behalf of the Inspector General, a check for witness fees and mileage need not accompany the subpoena.

[61 FR 65470, Dec. 13, 1996]

§ 498.211 Form, filing and service of papers.

(a) *Form.* (1) Unless the ALJ directs the parties to do otherwise, documents filed with the ALJ will include an original and two copies.

(2) Every document filed in the proceeding will contain a caption setting forth the title of the action, the case number, and a designation of the pleading or paper.

(3) Every document will be signed by, and will contain the address and telephone number of the party or the person on whose behalf the document was filed, or his or her representative.

(4) Documents are considered filed when they are mailed.

(b) *Service.* A party filing a document with the ALJ will, at the time of filing, serve a copy of such document on every other party. Service upon any party of any document will be made by delivering a copy, or placing a copy of the document in the United States mail, postage prepaid and addressed, or with a private delivery service, to the party's last known address. When a party is represented by an attorney, service will be made upon such attorney. Proof of service should accompany any document filed with the ALJ.

(c) *Proof of service.* A certificate of the individual serving the document by personal delivery or by mail, setting forth the manner of service, will be proof of service.

[61 FR 65470, Dec. 13, 1996]

§ 498.212 Computation of time.

(a) In computing any period of time under this part or in an order issued thereunder, the time begins with the day following the act, event or default, and includes the last day of the period unless it is a Saturday, Sunday or legal holiday observed by the Federal Government, in which event it includes the next business day.

(b) When the period of time allowed is less than 7 days, intermediate Saturdays, Sundays and legal holidays observed by the Federal Government will be excluded from the computation.

(c) Where a document has been served or issued by placing it in the mail, an additional 5 days will be added to the time permitted for any response. This paragraph does not apply to requests for hearing under § 498.202.

[61 FR 65470, Dec. 13, 1996]

§ 498.213 Motions.

(a) An application to the ALJ for an order or ruling will be by motion. Motions will:

(1) State the relief sought, the authority relied upon and the facts alleged; and

(2) Be filed with the ALJ and served on all other parties.

(b) Except for motions made during a prehearing conference or at a hearing, all motions will be in writing.

(c) Within 10 days after a written motion is served, or such other time as may be fixed by the ALJ, any party may file a response to such motion.

(d) The ALJ may not grant or deny a written motion before the time for filing responses has expired, except upon consent of the parties or following a hearing on the motion.

(e) The ALJ will make a reasonable effort to dispose of all outstanding motions prior to the beginning of the hearing.

(f) There is no right to appeal to the DAB any interlocutory ruling by the ALJ.

[61 FR 65470, Dec. 13, 1996]

§ 498.214 Sanctions.

(a) The ALJ may sanction a person, including any party or attorney, for:

(1) Failing to comply with an order or procedure;

(2) Failing to defend an action; or

(3) Misconduct that interferes with the speedy, orderly or fair conduct of the hearing.

(b) Such sanctions will reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

(1) In the case of refusal to provide or permit discovery under the terms of this part, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established;

(2) Prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense;

(3) Striking pleadings, in whole or in part;

(4) Staying the proceedings;

(5) Dismissal of the action; or

(6) Entering a decision by default.

(c) In addition to the sanctions listed in paragraph (b) of this section, the ALJ may:

(1) Order the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; or

(2) Refuse to consider any motion or other action that is not filed in a timely manner.

[61 FR 65471, Dec. 13, 1996]

§ 498.215 The hearing and burden of proof.

(a) The ALJ will conduct a hearing on the record in order to determine whether the respondent should be found liable under this part.

(b) In civil monetary penalty cases under §§ 498.100 through 498.132:

(1) The respondent has the burden of going forward and the burden of persuasion with respect to affirmative defenses and any mitigating circumstances; and

(2) The Inspector General has the burden of going forward and the burden of persuasion with respect to all other issues.

(c) The burden of persuasion will be judged by a preponderance of the evidence.

(d) The hearing will be open to the public unless otherwise ordered by the ALJ for good cause.

(e)(1) A hearing under this part is not limited to specific items and information set forth in the notice letter to the respondent. Subject to the 15-day requirement under § 498.208, additional items or information may be introduced by either party during its case-in-chief, unless such information or items are inadmissible under § 498.217.

(2) After both parties have presented their cases, evidence may be admitted on rebuttal as to those issues presented in the case-in-chief, even if not previously exchanged in accordance with § 498.208.

[61 FR 65471, Dec. 13, 1996]

§ 498.216 Witnesses.

(a) Except as provided in paragraph (b) of this section, testimony at the hearing will be given orally by witnesses under oath or affirmation.

(b) At the discretion of the ALJ, testimony (other than expert testimony) may be admitted in the form of a written statement. Any such written statement must be provided to all other parties along with the last known address of such witness, in a manner that allows sufficient time for other parties to subpoena such witness for cross-examination at the hearing. Prior written statements of witnesses proposed to testify at the hearing will be exchanged as provided in § 498.208.

(c) The ALJ will exercise reasonable control over the mode and order of witness direct and cross examination and evidence presentation so as to:

(1) Make the examination and presentation effective for the ascertainment of the truth;

(2) Avoid repetition or needless waste of time; and

(3) Protect witnesses from harassment or undue embarrassment.

(d) The ALJ may order witnesses excluded so that they cannot hear the testimony of other witnesses. This does not authorize exclusion of:

(1) A party who is an individual;

(2) In the case of a party that is not an individual, an officer or employee of the party appearing for the entity pro se or designated as the party's representative; or

(3) An individual whose presence is shown by a party to be essential to the presentation of its case, including an individual engaged in assisting the attorney for the Inspector General.

[61 FR 65471, Dec. 13, 1996]

§ 498.217 Evidence.

(a) The ALJ will determine the admissibility of evidence.

(b) Except as provided in this part, the ALJ will not be bound by the Federal Rules of Evidence, but may be guided by them in ruling on the admissibility of evidence.

(c) Although relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or by considerations of undue delay or needless presentation of cumulative evidence.

(d) Although relevant, evidence must be excluded if it is privileged under Federal law, unless the privilege is waived by a party.

(e) Evidence concerning offers of compromise or settlement made in this action will be inadmissible to the extent provided in Rule 408 of the Federal Rules of Evidence.

(f)(1) Evidence of crimes, wrongs or acts other than those at issue in the instant case is admissible in order to show motive, opportunity, intent, knowledge, preparation, identity, lack of mistake, or existence of a scheme.

(2) Such evidence is admissible regardless of whether the crimes, wrongs or acts occurred during the statute of limitations period applicable to the acts which constitute the basis for liability in the case, and regardless of whether they were referenced in the IG's notice sent in accordance with § 498.109.

(g) The ALJ will permit the parties to introduce rebuttal witnesses and evidence as to those issues raised in the parties' case-in-chief.

(h) All documents and other evidence offered or taken for the record will be open to examination by all parties, unless otherwise ordered by the ALJ for good cause.

[61 FR 65471, Dec. 13, 1996]

§ 498.218 The record.

(a) The hearing shall be recorded and transcribed. Transcripts may be obtained following the hearing from the ALJ.

(b) The transcript of testimony, exhibits and other evidence admitted at the hearing, and all papers and requests filed in the proceeding constitute the record for the decision by the ALJ.

(c) The record may be inspected and copied (upon payment of a reasonable fee) by any person, unless otherwise ordered by the ALJ for good cause.

[61 FR 65471, Dec. 13, 1996]

§ 498.219 Post-hearing briefs.

(a) Any party may file a post-hearing brief.

(b) The ALJ may require the parties to file post-hearing briefs and may permit the parties to file reply briefs.

(c) The ALJ will fix the time for filing briefs, which is not to exceed 60 days from the date the parties receive the transcript of the hearing or, if applicable, the stipulated record.

(d) The parties' briefs may be accompanied by proposed findings of fact and conclusions of law.

[61 FR 65471, Dec. 13, 1996]

§ 498.220 Initial decision.

(a) The ALJ will issue an initial decision, based only on the record, which will contain findings of fact and conclusions of law.

(b) The ALJ may affirm, deny, increase, or reduce the penalties or assessments proposed by the Inspector General.

(c) The ALJ will issue the initial decision to all parties within 60 days after the time for submission of post-hearing briefs or reply briefs, if permitted, has expired. The decision will be accompanied by a statement describing the right of any party to file a notice of appeal with the DAB and instructions for how to file such appeal. If the ALJ cannot issue an initial decision within the 60 days, the ALJ will notify the parties of the reason for the delay and will set a new deadline.

(d) Unless an appeal or request for extension pursuant to § 498.221(a) is filed with the DAB, the initial decision of the ALJ becomes final and binding on the parties 30 days after the ALJ serves the parties with a copy of the decision. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

[61 FR 65472, Dec. 13, 1996]

§ 498.221 Appeal to DAB.

(a) Any party may appeal the decision of the ALJ to the DAB by filing a notice of appeal with the DAB within 30 days of the date of service of the initial decision. The DAB may extend the initial 30-day period for a period of time not to exceed 30 days if a party files with the DAB a request for an extension within the initial 30-day period and shows good cause.

(b) If a party files a timely notice of appeal with the DAB, the ALJ will forward the record of the proceeding to the DAB.

(c) A notice of appeal will be accompanied by a written brief specifying exceptions to the initial decision and reasons supporting the exceptions, and identifying which finding of fact and conclusions of law the party is taking exception to. Any party may file a brief in opposition to exceptions, which may raise any relevant issue not addressed in the exceptions, within 30

days of receiving the notice of appeal and accompanying brief. The DAB may permit the parties to file reply briefs.

(d) There is no right to appear personally before the DAB, or to appeal to the DAB any interlocutory ruling by the ALJ.

(e) No party or person (except employees of the DAB) will communicate in any way with members of the DAB on any matter at issue in a case, unless on notice and opportunity for all parties to participate. This provision does not prohibit a person or party from inquiring about the status of a case or asking routine questions concerning administrative functions or procedures.

(f) The DAB will not consider any issue not raised in the parties' briefs, nor any issue in the briefs that could have been, but was not, raised before the ALJ.

(g) If any party demonstrates to the satisfaction of the DAB that additional evidence not presented at such hearing is relevant and material and that there were reasonable grounds for the failure to adduce such evidence at such hearing, the DAB may remand the matter to the ALJ for consideration of such additional evidence.

(h) The DAB may remand a case to an ALJ for further proceedings, or may issue a recommended decision to decline review or affirm, increase, reduce, or reverse any penalty or assessment determined by the ALJ.

(i) When the DAB reviews a case, it will limit its review to whether the ALJ's initial decision is supported by substantial evidence on the whole record or contained error of law.

(j) Within 60 days after the time for submission of briefs or, if permitted, reply briefs has expired, the DAB will issue to each party to the appeal and to the Commissioner a copy of the DAB's recommended decision and a statement describing the right of any respondent who is found liable to seek judicial review upon a final decision.

[61 FR 65472, Dec. 13, 1996]

§ 498.222 Final decision of the Commissioner.

(a) Except with respect to any penalty or assessment remanded to the ALJ, the DAB's recommended decision, including a recommended decision to decline review of the initial decision, shall become the final decision of the Commissioner 60 days after the date on which the DAB serves the parties to the appeal and the Commissioner with a copy of the recommended decision, unless the Commissioner reverses or modifies the DAB's recommended decision within that 60-day period. If the Commissioner reverses or modifies the DAB's recommended decision, the Commissioner's decision is final and binding on the parties. In either event, a copy of the final decision will be served on the parties. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

(b) There shall be no right to personally appear before or submit additional evidence, pleadings or briefs to the Commissioner.

(c)(1) Any petition for judicial review must be filed within 60 days after the parties are served with a copy of the final decision. If service is by mail, the date of service will be deemed to be five days from the date of mailing.

(2) In compliance with 28 U.S.C. 2112(a), a copy of any petition for judicial review filed in any U.S. Court of Appeals challenging a final action of the Commissioner will be sent by certified mail, return receipt requested, to the SSA General Counsel. The petition copy will be time-stamped by the clerk of the court when the original is filed with the court.

(3) If the SSA General Counsel receives two or more petitions within 10 days after the final decision is issued, the General Counsel will notify the U.S. Judicial Panel on Multidistrict Litigation of any petitions that were received within the 10-day period.

[61 FR 65472, Dec. 13, 1996]

§ 498.223 Stay of initial decision.

(a) The filing of a respondent's request for review by the DAB will automatically stay the effective date of the ALJ's decision.

(b)(1) After issuance of the final decision, pending judicial review, the respondent may file a request for stay of the effective date of any penalty or assessment with the ALJ. The request must be accompanied by a copy of the notice of appeal filed with the Federal

court. The filing of such a request will automatically act to stay the effective date of the penalty or assessment until such time as the ALJ rules upon the request.

(2) The ALJ may not grant a respondent's request for stay of any penalty or assessment unless the respondent posts a bond or provides other adequate security.

(3) The ALJ will rule upon a respondent's request for stay within 10 days of receipt.

[61 FR 65472, Dec. 13, 1996]

§ 498.224 Harmless error.

No error in either the admission or the exclusion of evidence, and no error or defect in any ruling or order or in any act done or omitted by the ALJ or by any of the parties is ground for vacating, modifying or otherwise disturbing an otherwise appropriate ruling or order or act, unless refusal to take such action appears to the ALJ or the DAB to be inconsistent with substantial justice. The ALJ and the DAB at every stage of the proceeding will disregard any error or defect in the proceeding that does not affect the substantial rights of the parties.

[61 FR 65472, Dec. 13, 1996]

PART 499 [RESERVED]