APPENDIX K--THE SOCIAL SECURITY ADMINISTRATION'S PRESUMPTIVE DISABILITY FORM FOR PHYSICIANS

PHYSICIAN'S REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

DO-BO CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form SSA-827 "Authorization To Release Medical Information to the Social Security Administration" attached.

☐ I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agen any medical records or other information regarding my treatment for Human Immunodeficiency Virus (HIV) Infection.

CLAIMANT'S SIGNATURE *(Required only if Form SSA-827 is NOT attached)* | Date

PHYSICIAN'S NAME | CLAIMANT'S NAME

A. PLEASE CHECK APPROPRIATE BLOCK

☐ HIV Test(s) Performed

☐ HIV Test(s) Not Performed

CLAIMANT'S SSN

CLAIMANT'S DATE OF BIRTH

B. PLEASE INDICATE RESULTS OF HIV TESTS(S)

☐ POSITIVE ☐ NEGATIVE

C. PLEASE INDICATE HERE:

CD4 (T4) LYMPHOCYTE COUNT: _____

or percent _____ if count not available

D. OPPORTUNISTIC AND INDICATOR DISEASES: ***Please Check, If Present***

1. ☐ HIV encephalopathy
2. ☐ HIV wasting syndrome
3. ☐ Carcinoma of the cervix, FIGO stage II and beyond
4. ☐ Anal squamous cell carcinoma
5. ☐ Cardiomyopathy
6. ☐ Nephropathy
7. ☐ Lymphoma of the brain
8. ☐ Hodgkin's disease
9. ☐ Non-Hodgkin's lymphoma (including Burkitt's lymphoma)
10. ☐ M. kansasii disease, disseminated other than or in addition to the lungs, skin, or cervical or hilar lymph nodes
11. ☐ Mycobacterium avium complex
12. ☐ Mycobacterial infection, disseminated beyond the lungs, lymph nodes

Protozoan or Helminthic Infections

13. ☐ Cryptosporidiosis, intestinal with diarrhea for 1 month or more
14. ☐ Isosporiasis, with diarrhea over 1 month
15. ☐ Pneumocystis carinii pneumonia
16. ☐ Strongyloidiasis, extra-intestinal
17. ☐ Toxoplasmosis of the brain
18. ☐ Toxoplasmosis, of an organ other than the liver, spleen, or lymph nodes

Fungal Infections

19. ☐ Candidiasis, of the esophagus, trachea, bronchi, or lungs
20. ☐ Candidiasis, disseminated beyond the skin, urinary or intestinal tract, or oral or vulvovaginal mucous membranes
21. ☐ Coccidioidomycosis, disseminated beyond the lungs, or lymph nodes
22. ☐ Cryptococcosis, disseminated beyond the lungs, or involving the central nervous system
23. ☐ Histoplasmosis, disseminated beyond the lungs or lymph nodes

Viral Infections

24. ☐ Cytomegalovirus, of an organ other than the liver, spleen, or lymph nodes
25. ☐ Herpes simplex virus, causing bronchitis
26. ☐ Herpes simplex virus, causing chronic continuous mucocutaneous infection, or infection of the pulmonary or gastrointestinal tract or encephalitis
27. ☐ Herpes simplex virus causing esophagitis
28. ☐ Herpes simplex virus, causing a mucocutaneous ulcer persistent over 1 month
29. ☐ Herpes simplex virus, causing pneumonitis
30. ☐ Progressive multifocal leukoencephalopathy

Bacterial Infections

31. Salmonella bacteremia, non-typhoid, recurrent
32 E I Nocardiosis

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK D, SKIP BLOCKS E, F, & G, GO TO BLOCKS I & J.

E. OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD, AND/OR RESISTANT TO THERAPY
(If one or more of the following is checked, block G must also be completed.)

33. ☐ Bacterial sepsis
34. ☐ Fungal sepsis
35. ☐ Endocarditis
36. ☐ Kaposi's sarcoma
37. ☐ Meningitis
38. ☐ Peripheral neuropathy
39. ☐ Pneumonia
40. ☐ Pulmonary tuberculosis
41. ☐ Septic arthritis

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK E, YOU NEED NOT COMPLETE BLOCK F, GO TO BLOCK G.

OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD, AND/OR RESISTANT TO THERAPY
(If two or more of the following are checked, block G must also be completed.)

2. ☐ Anemia—Hct. less than or equal to 30%
3. ☐ Granulocytopenia (absolute neutrophil count less than or equal to 1000/mm^3)
4. ☐ Thrombocytopenia (less than or equal to 40,000/mm^3)
5. ☐ Dermatological conditions, persistent
6. ☐ Diarrhea, persistent and unresponsive
7. ☐ Documented temperature of 100.4^{0}F (38^{0}C) or greater
48. ☐ Herpes zoster, chronic
49. ☐ Herpes zoster, recurrent
50. ☐ Oral hairy leukoplakia
51. ☐ Mucosal candidiasis (including vulvovaginal)
52. ☐ Sinusitus, persistent or recurrent
53. ☐ Weight loss of greater than or equal to 10% of baseline

. FUNCTIONAL LIMITATIONS: *(If any of the items in block E or F are checked, each of the following items must also be completed.)*

4. Restriction of activities of daily living including, but not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.
☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

5. Difficulties in maintaining social functioning, i.e., capacity to interact appropriately and communicate effectively with others. These restrictions could result from HIV- or treatment- induced fatigue or other symptoms or could result from a pattern of exacerbation and remission caused by the illness itself or its treatment.
☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

6. Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace, i.e., the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. This could result from symptoms such as extended or intermittent depression, fatigue, or physical functioning or both.
☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

7. Repeated episodes of deterioration or decompensation (averaging three times a year or once every four months, lasting two or more weeks each) in work or work-like settings. This may be caused by manifestations of HIV infection itself, such as its symptoms, or by the frequency and intrusiveness of treatment for the disease.
☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

. DISCUSSION: *(Please use this space to indicate any other medical conditions of your patient, or to provide any other comments you wish about your patient.)*

REPORTING PHYSICIAN'S NAME AND ADDRESS

TELEPHONE NUMBER *(Area Code)*

DATE

PHYSICIAN'S SIGNATURE
▶ **SIGN HERE**

☐ FIELD OFFICE DISPOSITION: ☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

RIVACY ACT NOTICE: The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(e)(1) the Social Security Act. The information, on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the formation on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's aim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such formation may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General ccounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and nprovement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

/e may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. he law allows us to do this even if you do not agree to it.

hese and other reasons why information about the claimant may be used or given out are explained in the *Federal Register*. If you want to learn more about is, contact any Social Security office.

IME IT TAKES TO COMPLETE THIS FORM

/e estimate that it will take you about 10 minutes to complete this form. This includes the time it will take to read the instructions gather the necessary facts and l out the form. If you have comments or suggestions on how long it takes to complete this form or on any other aspect of this form, write to the Social Security dministration. ATTN: Reports Clearance Officer, 1-A-21 Operations Bldg., Baltimore, MD 21235, and to the Office of Management and Budget, Paperwork eduction Project (0960-0057), Washington, D.C. 20503. **DO NOT SEND COMPLETED FORMS OR INFORMATION CONCERNING THIS CLAIM TO THESE FFICES. SEND THEM TO THE OFFICE THAT REQUESTED THE INFORMATION.**

NOWING THAT ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN ETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL AW, I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE.