

APPENDICES

<i>Commission Statute</i>	Appendix 1
<i>Commission Member Profiles</i>	Appendix 2
<i>Members of Congress, Administration Officials, Public Witnesses, and Expert Panels Who Addressed the Commission</i>	Appendix 3
* <i>Members of Congress and Administration Officials</i>	3-A
* <i>Public Witnesses</i>	3-B
* <i>Expert Panels</i>	3-C
<i>References</i>	Appendix 4
* <i>Books</i>	4-A
* <i>Journals and Periodicals</i>	4-B
* <i>Newspaper Articles</i>	4-C
* <i>Reports and Working Papers</i>	4-D
* <i>Social Security Administration Guides and Pamphlets</i>	4-E
* <i>Sullivan v. Zebley Supreme Court Decision</i>	4-F
<i>Senator Bob Packwood's Letter to Chairman Slattery and the Commission's Preliminary Recommendations</i>	Appendix 5
<i>Actuarial Estimates</i>	Appendix 6
* <i>Social Security Administration's Actuarial Estimates of Effects of Commission Recommendations on SSI Program</i>	6-A
* <i>Health Care Financing Administration's Estimated Medicaid Savings Due to Commission's Proposed Changes to Definition of Childhood Disability</i>	6-B
<i>Charts</i>	Appendix 7
* <i>Proposal to Modify the Definition of SSI Childhood Disability in HR 4</i>	7-A
* <i>Initial Determinations, Calendar Year 1994, A Comparison of Arkansas, Kansas, and Louisiana</i>	7-B
* <i>Estimated SSI Program Growth Under Two Alternatives for Revising the Definition of Disability</i>	7-C
* <i>SSI Childhood Disability Determinations: Initial Claims-Initial Allowances, February 11, 1991-December 31, 1994</i>	7-D
* <i>SSI Childhood Disability Determinations: Initial Allowance Impairment Groupings by Nation and State, February 11, 1991-December 31, 1994</i>	7-E
* <i>SSI Childhood Disability Determinations: Initial Claims-Initial Level Allowances-Primary Impairment by Regulation Basis, February 11, 1991-December 31, 1994</i>	7-F

APPENDICES—con't.

*Paper by Elizabeth Boggs, Ph.D.—'Balancing Equity and Efficiency:
Potential Improvements in SSI'*

Appendix 8

Individualized Functional Assessment Form

Appendix 9

Public Law 103-296

Social Security Independence and Program Improvements Act of 1994

Appendix 1

SEC. 202. COMMISSION ON CHILDHOOD DISABILITY.

(a) ESTABLISHMENT OF COMMISSION.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall appoint a Commission on the Evaluation of Disability in Children (in this section referred to as the “Commission”).

(b) APPOINTMENT OF MEMBERS.—(1) The Secretary shall appoint not less than 9 but not more than 15 members to the Commission, including—

(A) recognized experts in the field of medicine, whose work involves—

(i) the evaluation and treatment of disability in children;

(ii) the study of congenital, genetic, or perinatal disorders in children; or

(iii) the measurement of developmental milestones and developmental deficits in children; and

(B) recognized experts in the fields of—

(i) psychology;

(ii) education and rehabilitation;

(iii) law;

(iv) the administration of disability programs; and

(v) social insurance (including health insurance); and

(C) other fields of expertise that the Secretary determines to be appropriate.

(2) Members shall be appointed by January 1, 1995, without regard to the provisions of title 5, United States Code, governing appointments to competitive service.

(3) Members appointed under this subsection shall serve for a term equivalent to the duration of the Commission.

(4) The Secretary shall designate a member of the Commission to serve as Chair of the Commission for a term equivalent to the duration of the Commission.

(c) ADMINISTRATIVE PROVISIONS.—(1) Service as a member of the Commission by an individual who is not otherwise a Federal employee shall not be considered service in an appointive or elective position in the Federal Government for the purposes of title 5, United States Code.

(2) Each member of the Commission who is not a full-time Federal employee shall be paid compensation at a rate equal to the daily equivalent of the rate of basic pay in effect for Level IV of the Executive Schedule for each day (including travel time) the member attends meetings or otherwise performs the duties of the Commission.

(3) While away from their homes or regular places of business on the business of the Commission, each member who is not a full-time Federal employee may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons employed intermittently in the Government service.

(d) ASSISTANCE TO COMMISSION.—The Commission may engage individuals skilled in medical and other aspects of childhood disability to provide such technical assistance as may be necessary to carry out the functions of the Commission. The Secretary shall make available to the Commission such secretarial, clerical, and other assistance as the Commission may require to carry out the functions of the Commission.

Appendix 1

(e) STUDY BY THE COMMISSION.—(1) The Commission shall conduct a study, in consultation with the National Academy of Sciences, of the effects of the definition of “disability” under title XVI of the Social Security Act (42 U.S.C. 1382 et seq.) in effect on the date of enactment of this Act, as such definition applies to determining whether a child under the age of 18 is eligible to receive benefits under such title, the appropriateness of such definition, and the advantages and disadvantages of using any alternative definition of disability in determining whether a child under age 18 is eligible to receive benefits under such title.

(2) The study described in paragraph (1) shall include issues of—

(A) whether the need by families for assistance in meeting high costs of medical care for children with serious physical or mental impairments, whether or not they are eligible for disability benefits under title XVI of the Social Security Act, might appropriately be met through expansion of Federal health assistance programs;

(B) the feasibility of providing benefits to children through noncash means, including but not limited to vouchers, debit cards, and electronic benefit transfer systems;

(C) the extent to which the Social Security Administration can involve private organizations in an effort to increase the provision of social services, education, and vocational instruction with the aim of promoting independence and the ability to engage in substantial gainful activity;

(D) alternative ways and providing retroactive supplemental security income benefits to disabled children, including the desirability and feasibility of conserving some portion of such benefits to promote the long-term well-being of such children;

(E) the desirability and methods of increasing the extent to which benefits are used in the effort to assist disabled children in achieving independence and engaging in substantial gainful activity;

(F) the effects of the supplemental security income program on disabled children and their families; and

(G) such other issues that the Secretary determines to be appropriate.

(f) REPORT.—Not later than November 30, 1995, the Commission shall prepare a report and submit such report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate which shall summarize the results of the study described in subsection (e) and include any recommendations that the Commission determines to be appropriate.

Members of the National Commission on Childhood Disability

* *Polly Arango* is the parent of four children, one of whom has multiple disabilities. She is a co-founder and the director of Family Voices, a national grassroots network of families and friends speaking on behalf of children with special health care needs. She sits on local, state, and national boards related to health, disability, children, and family issues, and is the author of many articles about children with special needs and their families.

* *Adrienne Asch, Ph.D.*, is the Henry R. Luce Professor of Biology, Ethics, and the Politics of Human Reproduction at Wellesley College, Wellesley, Massachusetts. Dr. Asch is an ethicist and social psychologist who has researched legal and ethical problems in health care delivery. She has written extensively on disability, bioethics, and reproductive technology.

* *Dolores Berkovsky, MSN, LMSW*, is Director of Children's Services at Catholic Charities of Fort Worth, Texas. Ms. Berkovsky is responsible for a large continuum of child and family services, including programs for residential treatment, family preservation, foster care, adoption of children with disabilities, out-patient assessment, and treatment services.

* *Wade F. Horn, Ph.D.*, is Director of the National Fatherhood Initiative, a group that promotes enhancing the role of the father in families. Dr. Horn is a clinical child psychologist and a nationally recognized expert on Attention Deficit Hyperactivity Disorder. In 1993, Dr. Horn served as the National Executive Director of Children and Adults with Attention Deficit Disorders. During the Bush Administration, he served as the Commissioner for Children, Youth, and Families and chief of the Children's Bureau in the Administration for Children and Families. Dr. Horn also served as a Presidential appointee to the National Commission on Children from 1989 to 1993.

* *Jennifer Howse, Ph.D.*, is President of the March of Dimes Birth Defects Foundation. Dr. Howse previously served as Associate Commissioner for the Office of Mental Retardation and Developmental Disabilities for the State of New York. She also has served as the Executive Director of the Greater New York March of Dimes and the Pennsylvania State Commission for Mental Retardation.

* *Sharman Davis Jamison* is the coordinator of two national technical assistance projects located at the Parent Advocacy Coalition Educational Rights (PACER) Center, both of which address family and consumer concerns about transition, supported employment, and the Rehabilitation Act. Ms. Jamison, the mother of an adult daughter who is autistic and deaf, is also a member of the President's Committee on Employment of Persons with Disabilities and the National Advisory Committee of the Howard University Research and Training Center.

Appendix 2

* *Dan Johnson* is Director of the Office for Persons with Physical Disabilities, Wisconsin Department of Health and Social Services. Mr. Johnson is responsible for the development and coordination of programs which provide the services essential to promote independence and self-sufficiency among persons with physical disabilities.

* *Paul Marchand* is Director of the National Governmental Affairs Office of The Arc. He is a leading spokesperson for children with mental impairments. Mr. Marchand actively assists Congress and federal agencies in formulating programs and benefits for individuals with mental retardation and their families. He also serves as the Chairman of the Consortium for Citizens with Disabilities, a Washington-based coalition of over 100 national disability organizations involved in public policy.

* *James M. Perrin, M.D.*, is an Associate Professor of Pediatrics at Harvard Medical School and Director of the Division of General Pediatrics at Massachusetts General Hospital in Boston, Massachusetts. Dr. Perrin has written extensively on the organization of services for children with chronic conditions and co-authored *Home and Community Care for Chronically Ill Children* and *Chronically Ill Children and Their Families*. He currently chairs the American Academy of Pediatrics Committee on Children with Disabilities.

* *M. Carmen S. Ramirez* is Founder and President of Schools Are for Everyone (SAFE), El Paso, Texas chapter. Ms. Ramirez volunteers extensively in her community and works on behalf of children with disabilities and their families. She is a member of the Executive Board for the Association of People with Severe Handicaps, the Texas Continuing Advisory Commission for Special Education, and the Governing Commission of the Texas Parent and Training Information Center for Latino Parents of Children with Disabilities.

* *Carol Rank, M.S., M.P.A.*, is Acting Director of the Kansas Disability Determination and Referral Service. Ms. Rank works closely with Kansas State Services for Children with Special Health Care Needs to help facilitate a better understanding of the eligibility requirements for the Supplemental Security Income program for children with disabilities.

* *Jim Slattery* is a former United States Representative from the Second District of Kansas. He currently is a partner in the law firm of Wiley, Rein, and Fielding. Mr. Slattery was elected to the House of Representatives in 1982 and served six terms. He served twelve years on the House Energy and Commerce Committee, where he was active on environmental, health care, telecommunications, and railroad issues. Mr. Slattery also served for six years on the House Budget Committee and was chairman of the House Veterans' Affairs Subcommittee on Compensation, Pension, and Insurance.

* ***Rud Turnbull, LL.B./J.D., LL.M.***, is Co-director of the Beach Center on Families and Disability, a rehabilitation research and training center at The University of Kansas, where he is also Professor of Special Education and Courtesy Professor of Law. Mr. Turnbull, the father of a son who has mental retardation and autism, is an expert and author in disability policy. He has served as President, American Association on Mental Retardation; Secretary, The Arc; Treasurer, The Association for Persons with Severe Disabilities; and Chairman, American Bar Association Commission on Mental and Physical Disability Law.

* ***Barbara Wolfe, Ph.D.***, is Director of the Institute for Research on Poverty at the University of Wisconsin, where she is also a member of the faculty of the Department of Economics, the Department of Preventive Medicine, and the LaFollette Institute of Public Affairs. Dr. Wolfe has authored a number of publications on health policy issues, including a book, *Succeeding Generations: On the Effect of Investments in Children*.

*Members of Congress and Administration Officials
Who Testified Before the Commission*

Members of Congress

Representative Harold Ford

Democrat

Tennessee, 9th Congressional District

Representative Blanche Lambert Lincoln

Democrat

Arkansas, 1st Congressional District

Representative Sander Levin

Democrat

Michigan, 12th Congressional District

Representative James McCrery

Republican

Louisiana, 5th Congressional District

Administration Officials

Donna Shalala, Ph.D.

Secretary

Department of Health and Human Services

200 Independence Avenue, S.W.

Washington, D.C. 20201

Shirley Sears Chater, Ph.D.

Commissioner

Social Security Administration

Universal South Building

1825 Connecticut Avenue, N.W., Suite 714

Washington, D.C. 20009

Appendix 3-A

Ms. Michele Adler

Statistician
Office of Disability, Aging, and Long-term
Care Policy
Department of Health and Human Services
200 Independence Avenue, S.W., Room 424E
Washington, D.C. 20201

Ms. Rachel Block

Director, Office of Planning and Special Initiatives
Health Care Financing Administration
Room 233 East High Rise
6325 Security Boulevard
Baltimore, Maryland 21207

Ms. Carol Cohen

Program Manager for Assistive Technology
National Institute on Disability
and Rehabilitation Research
Department of Education
600 Independence Avenue, S.W.
Washington, D.C. 20202

Ms. Beverly Crawford

Team Leader, SSI Outreach
Social Security Administration
3-R-1 Operations Building
6401 Security Boulevard
Baltimore, Maryland 21235

Mr. Gary DeCarolis

Chief, Child, Adolescent, and Family Branch
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Public Health Service
5600 Fishers Lane, Room 11C-17
Rockville, Maryland 20857

Appendix 3-A

Mr. Barry Eigen

Deputy Director, Division of Medical and
Vocational Policy
Office of Disability
Social Security Administration
3-A-8 Operations Building
6401 Security Boulevard
Baltimore, Maryland 21235

Ms. Lisa Elliott

Certified Disability Examiner
Ohio Bureau of Disability Determinations
400 East Campus View Boulevard
Columbus, Ohio 43235

Connie Garner, Ph.D.

Senior Policy Analyst, Department of Education
330 C Street, S.W., Room 3127
Washington, DC 20004

Ms. Diane Garro

Acting Executive Program Policy Officer
Office of Disability
Social Security Administration
560 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235

Mr. Frank Gigliotti

Social Insurance Specialist, Office of Program
Benefits Policy
Social Security Administration
3-M-2 Operations Building
6401 Security Boulevard
Baltimore, Maryland 21235

Mr. Fred Graf

Program Policy Adviser, Office of Program
Benefits Policy
Social Security Administration
760 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235

Appendix 3-A

Ms. Ellen Habenicht

Evaluator, General Accounting Office
441 G Street, N.W., Suite 400
NGB/HEHS
Washington, D.C. 20548

Mr. Guy Hammer

Team Leader for Technology
National Institute on Disability
and Rehabilitation Research
Department of Education
600 Independence Avenue, S.W.
Washington, D.C. 20202

Mr. Ron Haskins

Staff Director, Subcommittee on Human Resources
Committee on Ways and Means
United States House of Representatives
B-318 Rayburn House Office Building
Washington, D.C. 20515

Mr. Charles Haven

Chief, Childhood Disability Branch
Office of Disability
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

Mr. William Hickman

Associate Director, Medicaid Bureau
Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244

Ms. Michelle Hungerman

Policy Analyst, Childhood Disability Branch
Office of Disability
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

Appendix 3-A

Mr. Steve Jacobs

Social Insurance Specialist, Office of Program
Benefits Policy
Social Security Administration
3-L-3 Operations Building
6401 Security Boulevard
Baltimore, Maryland 21235

Mr. Don Johnson

Director, Division of Medicaid
Office of Legislative and Intergovernmental Affairs
Health Care Financing Administration
200 Independence Avenue
Washington, DC 20201

Eileen F. Kasten, MD.

Medical Consultant, Ohio Bureau of
Disability Determinations
400 East Campus View Boulevard
Columbus, Ohio 43235

Mr. Michael Kowal

Audit Manager, Office of Inspector General
Social Security Administration
300 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235

Ms. Susan LaMorte

Northeast Regional Director, National Association
of Disability Examiners
675 Joralemon Street, Suite A-10
Belleville, New Jersey 07109

John Mather, MD.

Chief Medical Director, Social Security Administration
Security West Building, Room 2040
1500 Woodlawn Drive
Baltimore, Maryland 21241

Appendix 3-A

Caroll McBrine, MD.

Medical Consultant, Department of Veterans' Affairs
810 Vermont Avenue, N.W., Suite 211B
Washington, D.C. 20420

Ms. Virginia McNeely

Regional Manager, Disability Evaluation Division
California Department of Social Services
744 P Street
Sacramento, California 95814

Mr. Rene Parent

Social Insurance Specialist, Office of Program
Benefits Policy
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

William Payne, MD.

Chief, Medical Consultant Staff
State of Arkansas Disability Determination
for Social Security Administration
701 Pulaski Street
Little Rock, Arkansas 72201

Mr. Thomas Robertson

Regional Inspector General for Audit Services
Office of Inspector General
3535 Market Street, Room 4300
Philadelphia, Pennsylvania 19104

Ellen Schiller, Ph.D.

Branch Chief, Division of Innovation
and Development
Department of Education
600 Independence Avenue, S.W.
Washington, D.C. 20202

Appendix 3-A

Katherine Seelman, Ph.D.

Director, National Institute on Disability
and Rehabilitation Research
Department of Education
600 Independence Avenue, S.W.
Washington, D.C. 20202

Ms. Lily Mae Stark

Assistant Director, Training, Quality Assurance,
and Disability Hearings Branch
State of Arkansas Disability Determination
for Social Security Administration
701 Pulaski Street
Little Rock, Arkansas 72201

Mr. Larry Thompson

Principal Deputy Commissioner
Social Security Administration
900 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235

Ms. Ruth Wishard

Program Manager, Medical Services Unit
Bureau of Disability Determination
South Cameron Street
Harrisburg, Pennsylvania 17104

Ms. Ilene Zeitzer

Special Assistant to the Associate Commissioner
Office of Disability
560 Altmeyer Building
6401 Security Boulevard
Baltimore, Maryland 21235

Public Witnesses Who Testified Before the Commission

Mr. Willie Bell

Principal
Southside Elementary School
Lake Providence, Louisiana 71266

Elizabeth Boggs, Ph.D.

Hampton, New Jersey

Reverend Walter Brandon

Sickle Cell Genetic Disease Council,
Southeastern Pennsylvania
Sickle Cell Disease Association of America
Philadelphia Chapter, Delaware Valley

Ms. Debra A. Bransley

Baltimore, Maryland

Ms. Gloria Brown

Attorney
Community Legal Services, Inc.
1424 Chestnut Street
Philadelphia, Pennsylvania 19102

Ms. Herlena Brown

Ms. Diane Cabot

Executive Director
Mental Health Association of
Metropolitan Maryland
323 East 25th Street
Baltimore, Maryland 21218

Ms. Barbara Carlow

Association for Retarded Citizens

Kenneth R. Carroll, Ph.D.

Psychologist

Ms. Nicole Carter

Appendix 3-B

Ms. Anita Chalupa
Parents Place of Maryland

Ms. Vanessa Cooke
Philadelphia, Pennsylvania

Ms. Gail Daniels

Ms. Sandra Eagles
Germantown, Maryland

Ms. Paula Flaherty

Ms. Maureen Gill
Children and Adults with
Attention Deficit Disorder
3819 Beech Down Drive
Chantilly, Maryland 22021

Ms. Sharon Harper

Ms. Carol Harrison
Baltimore, Maryland 21217

Mr. Tom Hvalocheck
Coalition for Advocacy

Ms. Charol Jamison
Philadelphia, Pennsylvania

Ms. Michele Kelly

Mr. Tariq Kelly

Ms. Yvonne Manuel
Chair
Sickle Cell Parents Group of Philadelphia

Ms. Katke Maus

Ms. Kate Miles
Lusby, Maryland

Appendix 3-B

Ms. Robin Murphy
Parents Place of Maryland

Ms. Susie Murphy
Family Friends

Ms. Dianne Nichols

David Osher, Ph.D.
Takoma Park, Maryland 20912

Mr. Ray Owens
Pupil Appraisal Coordinator
Morehouse Parish, Louisiana

Ms. Sara Pitt

Ms. Alisa Phillips

Ms. Estelle Richman
Health Commissioner for Philadelphia

Ms. Brenda L. Robinson
Lusby, Maryland

Ms. Carlita Rodgers
Baltimore, Maryland

Ms. Kate Rollason
Lusby, Maryland

Ms. Marge Samuels

Mr. Brian Smith

Ms. Juanita Smith

Ms. Evelyn Sostra
Philadelphia, Pennsylvania

Ms. Anna Stokes
Baltimore, Maryland

Appendix 3-B

Mr. Tom Sutton

Attorney
Community Legal Services, Inc.
1424 Chestnut Street
Philadelphia, Pennsylvania 19102

Ms. Deborah Weinstein

Director
Family Income Division
The Children's Defense Fund
25 E Street NW
Washington, DC 20001

Ms. Sharon Williams

Ms. Heidi Windman

Baltimore, Maryland

Ms. Shelly Yanoff

Executive Director
Philadelphia Citizens for Children and Youth

Bornie Zetick, Ph.D.

Executive Director
The ARC
Philadelphia Chapter

Members of Expert Panels Who Testified Before the Commission

John Agosta, Ph.D.

Senior Research Associate, Human Services
Research Institute
525 Glen Creek Road, Suite 230
Salem, Oregon 97304

Ms. Laudan Aron

Research Associate, The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037

Mark Batshaw, M.D.

Physician-in-Chief, Children's Seashore House
Philadelphia, Pennsylvania 19104

Ms. Julianne Beckett

National Coordinator, Family Voices
4555 Westchester Drive N.E., Unit D
Cedar Rapids, Iowa 52402

Karen Berberian, Ph.D.

Director of Child Psychology for the
Section of Developmental and Behavioral Pediatrics
St. Christopher's Hospital for Children
Front Street at Erie Avenue
Philadelphia, Pennsylvania 19134

Mr. Allan Bergman

Director, State-Federal Relations
United Cerebral Palsy Associations, Inc.
1660 L Street N.W., Suite 700
Washington, DC 20036

Jane Costello, Ph.D.

Associate Professor, Developmental
Epidemiology Program
Department of Psychiatry
Duke Medical Center, Box 3454
Duke University
Durham, North Carolina 27710

Appendix 3-C

Ms. Shirley Cramer

Executive Director, National Center for
Learning Disabilities
381 Park Avenue South, Suite 1420
New York, New York 10016

Mr. Kevin Dwyer

Assistant Executive Director, National Association of
School Psychologists
8455 Colesville Road, Suite 1000
Silver Spring, Maryland 20910

Ms. Suzanne Enright

Director for Children's Services
Montgomery County Pennsylvania
Association for Retarded Citizens
Continental Plaza, 1010 West 9th Avenue
King of Prussia, Pennsylvania 19406

Ms. JoAnne Evans

National President, Children and Adults with
Attention Deficit Disorders
625 Shoreline Court
Eau Claire, Wisconsin 54703

Ms. Barbara Huff

Executive Director, Federation of Families for
Children's Mental Health
1021 Prince Street
Alexandria, Virginia 22314

Pamela Loprest, Ph.D.

Research Associate, The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037

Myles Maxfield, Ph.D.

Principle Researcher, Mathematica Policy
Research, Inc.
600 Maryland Avenue S.W., Suite 550
Washington, D.C. 20024

Appendix 3-C

Ms. Patricia McGill Smith

Executive Director, National Parent Network
on Disabilities
1727 King Street, Suite 305
Alexandria, Virginia 22314

John A. Nackashi, MD.

American Academy of Pediatrics
General Pediatrics
Box J 296JHMH
Gainesville, Florida 32610

Allan Reiss, MD.

Director, Behavioral Neurogenetics and
Neuroimaging Center
707 North Broadway Street, Room 509
Baltimore, Maryland 21205

Ms. Virginia Reno

Director, Disability Project
National Academy of Social Insurance
1776 Massachusetts Avenue, N.W., Suite 615
Washington, D.C. 20036

Mr. Ed Salisbury

Assistive Technology Specialist
Assistive Technology Resource Center
Easter Seal of Del-Mar
Kent County Community School
Carver Road
Dover, Delaware 19901

Ms. Rhoda Schulzinger

Director, Children's SSI Campaign
Bazelon Center for Mental Health Law
1101 15th Street N.W., Suite 1212
Washington, DC 20005

Appendix 3-C

Mr. J. Joseph Scullin

Director of Community Social Services
United Cerebral Palsy Association of
Philadelphia and Vicinity
102 East Mermaid Lane
Philadelphia, Pennsylvania 19118

Ms. Sharon Sheldon

Coordinator for Family Support Services
Texas Children's Mental Health Plan
6518 Heron Drive
Austin, Texas 78759

Deborah Spitalnik, Ph.D.

Executive Director, University Affiliated Programs
of New Jersey
45 Knightsbridge Road
Brookwood 2 Corporate Building
Post Office Box 6810
Piscataway, New Jersey 08855-6810

Mr. Jonathan M. Stein

Attorney
Community Legal Services, Inc.
1424 Chestnut Street
Philadelphia, Pennsylvania 19102

C. Eugene Steurele, Ph.D.

Senior Fellow, The Urban Institute
2100 M Street, N.W.
Washington, D.C. 20037

Gary Stoner, Ph.D.

Associate Professor, School of Education
and Psychology
University of Oregon
1215 University of Oregon
Eugene, Oregon 97403

Appendix 3-C

Mr. Vince Tarantella

Association for Retired Citizens
Continental Plaza
1010 West 9th Avenue
King of Prussia, Pennsylvania 19406

Ms. Symme Trachtenberg

Director of Social Services
Children's Seashore House
Philadelphia, Pennsylvania 19104

Mr. Richard Weishapt

Attorney
Community Legal Services, Inc.
1424 Chestnut Street
Philadelphia, Pennsylvania 19102

Mark L. Wolraich, MD.

Director, Child Development Center
Vanderbilt University Medical Center South
2100 Pierce Avenue
Nashville, Tennessee 37232

Mr. Thomas Yates

Attorney, Legal Assistance Foundation
of Chicago
1661 South Blue Island Avenue
Chicago, Illinois 60608

Books

- Batshaw, M., & Perret, Y. *Children with Disabilities: A Medical Primer*. Baltimore, Maryland: Paul H. Brookes Publishing Co., 1992.
- Birenbaum, A., Guyot, D., & Cohen, H. *Health Care Financing for Severe Developmental Disabilities*. Washington, D.C.: American Association on Mental Retardation, 1990.
- Braddock, D., & Hemp, R. *The State of the States in Developmental Disabilities* (4th ed.). Washington, D.C.: American Association on Mental Retardation, 1995.
- Braybrooke, D. *Meeting Needs*. Princeton, New Jersey: Princeton University Press, 1987.
- Brett, A., & Provenzo, E., Jr. *Adaptive Technology for Special Human Needs*. Albany, New York: State University of New York Press, 1995.
- Browning, E., & Browning, J. *Public Finance and the Price System*. New York, New York: MacMillan Publishing Company, 1987.
- Callahan, D. *What Kind of Life: The Limits of Medical Progress*. Washington, D.C.: Georgetown University Press, 1990.
- Colligen, B. (Ed.) *Pharmaceutical Benefits Under State Medical Assistance Programs*. Reston, Virginia: National Pharmaceutical Council, 1994.
- Daniels, N. *Just Health Care: Studies in Philosophy and Health Policy*. Cambridge, England: Cambridge University Press, 1985.
- Derthick, M. *Agency Under Stress*. Washington, D.C.: The Brookings Institution, 1990.
- Enders, A., & Hall, M. (Eds.). *Assistive Technology Sourcebook*. Washington, D.C.: Resna Press, 1990.
- EPSDT: Does It Spell Health Care for Poor Children?* Washington, D.C.: The Children's Defense Fund, 1977.
- Gliedman, J., & Roth, W. *The Unexpected Minority: Handicapped in America*. New York, New York: Carnegie Corporation, 1980.
- Granneman, T., & Pauly, M. *Controlling Medicaid Costs: Federalism, Competition, and Choice*. Washington, D.C.: American Enterprise Institute Studies in Health Policy, 1983.

Appendix 4-A

- Hallowell, E., & Ratey, J. *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood*. New York, New York: Simon & Schuster, 1994.
- Hoagwood, K., & Rupp, A. "Mental Health Service Needs, Use, and Costs for Children and Adolescents with Mental Disorders and their Families: Preliminary Evidence." In R. Manderscheid & M. Sonnenschein (Eds.), *Mental Health, United States*. Washington, D.C.: Department of Health and Human Services, 1994.
- Hochschild, J. *What's Fair? American Beliefs about Distributive Justice*. Cambridge, Massachusetts: Harvard University Press, 1981.
- Levine, D., Zitter, M., & Ingram L. *Disability Statistics: An Assessment*. Washington, DC: National Academy Press, 1990.
- Nagi, S. "Disability Concepts Revisited: Implications for Prevention." In A. Pope and A. Tarlov (Eds.), *Disability in America: Toward a National Agenda for Prevention* Appendix A, pp. 309-327). Washington, DC: National Academy Press, 1991.
- National Research Council. *Measuring Poverty: A New Approach*. Washington, D.C.: National Academy Press, 1995.
- Perrin, J., Shayne, M., & Bloom, S. *Home and Community Care for Chronically Ill Children*. Cary, N.C.: Oxford University Press, 1993.
- Salkever, D. "Parental Opportunity Costs and Other Economic Costs of Children's Disabling Conditions." In N. Hobbs, & J. Perrin (Eds.), *Issues in the Care of Children with Chronic Illness*. San Francisco, California: Jossey-Bass Publishers, 1985.
- Savas, E. *Privatizing the Public Sector*. Chatham House Publishers, Inc., 1982.
- Sherman, A. *Wasting America's Future. The Children's Defense Fund Report on the Costs of Child Poverty*. Boston, Massachusetts: Beacon Press, 1994.
- World Health Organization. *International Classification of Impairments, Disabilities, and Handicaps*. Geneva, Switzerland: World Health Organization, 1980.

Journals and Periodicals

- Alstott, A. "The Earned Income Tax Credit and Some Fundamental Institutional Dilemmas of Tax-Transfer Integration." *National Tax Journal*, 47: September 1994.
- Benjamin, A., Newacheck, P., & Wolfe, H. "Intergenerational Equity and Public Spending." *Pediatrics*, 88: 75-83; July 1991.
- Birenbaum, A., & Cohen, H. "Mini-Symposium: Helping Families." *Mental Retardation*, 31(2): 67-74; 1993.
- Bixby, A. "Public Social Welfare Expenditures, Fiscal Year 1991." *Social Security Bulletin*, 7(1): 6; March 1994.
- Blackman, J., Healy, A., & Ruppert, E. "Participation by Pediatricians in Early Intervention: Impetus from Public Law 99-457." *Pediatrics*, 89: 98-102; January 1992.
- Boyle, C., Decoufle, P., & Yeargin-Allsopp, M. "Prevalence and Health Impact of Developmental Disabilities in U.S. Children." *Pediatrics*, 93: 399-403; March 1994.
- Breslau, N., Salkever, D., & Staruch, K. "Women's Labor Force Activity and Responsibilities for Disabled Dependents: A Study of Families with Disabled Children." *Journal of Health and Social Behavior*, 23: 169-183; June 1982.
- Brewer, E., Jr., McPherson, M., Magrab, P., & Hutchins, V. "Family-Centered, Community-based, Coordinated Care for Children with Special Health Care Needs." *Pediatrics*, 83: 1055-1060; June 1989.
- Butler, J., Singer, J., Palfrey, J., & Walker, D. "Health Insurance Coverage and Physician Use Among Children with Disabilities: Findings from Probability Samples in Five Metropolitan Areas." *Pediatrics*, 79: 89-98; January 1987.
- Cartland, J., McManus, M., & Flint, S. "A Decade of Medicaid in Perspective: What Have Been the Effects on Children?" *Pediatrics*, 91: 287-295; February 1993.
- Chernoff, R., & Combs-Orme, T. "Assessing the Health Status of Children Entering Foster Care." *Pediatrics*, 93: 594-601; April 1994.
- Cohen, H. "Child Care for Children with Special Needs." *Pediatrics*, 94: 1055-1059; December 1994.

Appendix 4-B

- Desch, L. "High Technology for Handicapped Children: A Pediatrician's Viewpoint." *Pediatrics*, 77: 71-87; January 1986.
- Disability Policy Panel of the National Academy of Social Insurance. "Rethinking Disability Policy: The Role of Income, Health Care, Rehabilitation, and Related Services in Fostering Independence." *Social Security Bulletin*, 7(2): 6; June 22, 1994.
- Dworkin, P. "Developmental Screening -- Expecting the Impossible?" *Pediatrics*, 83: 619-622; April 1989.
- Eyman, R., Grossman, H., Chaney, R., & Call, T. "The Life Expectancy of Profoundly Handicapped People with Mental Retardation." *New England Journal of Medicine*, 323: 584-589; August 1990.
- "Family Support: States Set the Stage for Federal Legislation." *Family Support Bulletin (United Cerebral Palsy Association)*, Winter 1992/93.
- Frankenburg, W. "Preventing Developmental Delays: Is Developmental Screening Sufficient?" *Pediatrics*, 93: 586-593; April 1994.
- Fujiura, G., Roccoforte, J., & Braddock, D. "Costs of Family Care for Adults with Mental Retardation and Related Developmental Disabilities." *American Journal on Mental Retardation*, 99(3): 250-261; 1994.
- Gurny, P., Baugh, D., & Davis, F. "A Description of Medicaid Eligibility; Medicare and Medicaid Statistical Supplement." *Health Care Financing Review*, 14: 207; January 1992.
- Halfon, N., Berkowitz, G., & Klee, L. "Mental Health Service Utilization by Children in Foster Care in California." *Pediatrics*, 89: 1238-1244; June 1992.
- Hemp, R., Braddock, D., Lakin, K., & Smith, G. "Trends and Milestones: The Growth of Family Support." *Mental Retardation*, August 1994.
- Herman, S. "Cash Subsidy Program: Family Satisfaction and Need." *Mental Retardation*, 32(6): 416-421; 1994.
- Holtzblatt, J., McCubbin, J., & Gillette, R. "Promoting Work through the EITC." *National Tax Journal*, 47: September 1994.
- Houk, V., & Thacker, S. "The Centers for Disease Control Program to Prevent Primary and Secondary Disabilities in the United States." *Public Health Reports*, 104: 226-231; May 1989.

Appendix 4-B

- Howard, C. "Happy Returns, How the Working Poor Got Tax Relief." *The American Prospect*, Spring 1994.
- Hughes, M., Goldman, B., & Snyder, N. "Hyperactivity and Attention Deficit Disorder." *American Family Physician*, 27(6): 119-126; June 1983.
- Ireys, H., & Nelson, R. "New Federal Policy for Children with Special Health Care Needs: Implications for Pediatricians." *Pediatrics*, 90: 321-327; September 1992.
- Kerns, W. "Private Social Welfare Expenditures, 1972-91." *Social Security Bulletin*, 7(1): 7; March 1994.
- Korpela, R., Siirtola, T., & Koivikko, M. "The Cost of Assistive Devices for Children with Mobility Limitation." *Pediatrics*, 90: 597-602; October 1992.
- LaPlante, M. "The Demographics of Disability." *The Milbank Quarterly*, 68: 55-77; 1991.
- LaPlante, M. "Using the Survey of Income and Program Participation in Disability Research and Policy." *Journal of Economic and Social Measurement*, 18: 125-154; 1992.
- Leonard, B., Brust, J., & Choi, T. "Providing Access to Home Care for Disabled Children: Minnesota's Medicaid Model Waiver Program." *Public Health Report*, 104: 465-472; September/October 1989.
- Leonard, B., Dwyer Brust, J., & Sapienze, J. "Financial and Time Costs to Parents of Severely Disabled Children." *Public Health Reports*, 107: 302-312; May 1992.
- Lowe, B. "American Academy of Pediatrics Task Force Report on the Future Role of the Pediatrician in the Delivery of Health Care." *Pediatrics*, 87: 401-409; March 1991.
- Lowe, B., & Barnett, S. "Integrated School Health Services." *Pediatrics*, 94: 400-402; September 1994.
- Mann, W., & Lane, J. (Eds.). *Technology and Disability*, 3(2): May 1994.
- Marcenko, M., & Meyers, J. "How Families of Children with Severe Disabilities Choose to Allocate a Cash Subsidy." *The Journal of Mental Health Administration*, 21: 3; 1994.
- McCoy, J., Davis, M., Hudson, R. "Geographic Patterns of Disability in the United States." *Social Security Bulletin*, 7(1): 5; March 1994.

Appendix 4-B

- McLaughlin, J., & Gustafson, C. "Developmentally Disabled Infants Can Be Hard to Trace." *Clinical Pediatrics*, 23: 204-208; April 1984.
- McManus, M., & Newacheck, P. "Health Insurance Differentials Among Minority Children with Chronic Conditions and the Role of Federal Agencies and Private Foundations in Improving Financial Access." *Pediatrics*, 91(suppl): 1040-1047; May 1993.
- McManus, M., Newacheck, P., & Greaney, A. "Young Adults with Special Health Care Needs: Prevalence, Severity, and Access to Health Services." *Pediatrics*, 86: 674-682; November 1990.
- Miesels, S. "Can Developmental Screening Tests Identify Children Who Are Developmentally at Risk?" *Pediatrics*, 83: 578-585; April 1989.
- Miesels, S., & Margolis, L. "Is the Early and Periodic, Diagnostic, and Treatment Program Effective with Developmentally Disabled Children?" *Pediatrics*, 81: 262-271; February 1988.
- National Easter Seal Society. *Project Action Update*, Summer 1995.
- National Governors' Association. "State Coverage of Pregnant Women and Children -- February 1995." *MCH Update*; March 1995.
- Newacheck, P., & McManus, M. "Financing Health Care for Disabled Children." *Pediatrics*, 81: 385-94; 1988.
- Newacheck, P., McManus, M., & Fox, H. "Prevalence and Impact of Chronic Illness Among Adolescents." *American Journal of Diseases of Children*, 145: 1367-1373; 1991.
- Newacheck, P., & Stoddard, J. "Prevalence and Impact of Multiple Children Chronic Illnesses." *Journal of Pediatrics*, 124: 39-47; January 1994.
- Oberg, C. "Medically Uninsurable Children in the United States: A Challenge to Public Policy." *Pediatrics*, 85: 824-833; May 1990.
- Palfrey, J. "Prevalence of Medical Technology Assistance Among Children in Massachusetts in 1987 and 1990." *Public Health Reports*, 109: 226-233; March 1994.

Appendix 4-B

- Parrino, S., & Thacker, S. "The Challenge of Day-Care Health Among Children with Disabilities." *Pediatrics*, 94: 1052-1055; December 1994.
- Perrin, J. "Provision of Related Services for Children with Chronic Disabilities." *Pediatrics*, 92: 879-881; December 1993.
- Perrin, J., & Stein, R. "Reinterpreting Disability: Changes in Supplemental Security Income for Children." *Pediatrics*, 88: 1047-1051; November 1991.
- Prero, A. "Shifting the Cost of Self-Pay for SSI Workers in Supported Employment; Supplemental Security Income." *Social Security Bulletin*, 6(1): 4; March 1993.
- "Preventive Health Care for Young Children: Findings from a 10-Country Study and Directions for United States Policy." *Pediatrics*, 89(suppl): 983-998; May 1992.
- Riley, A. "Interagency Coordination: The Key to Mainstreaming Children with Special Needs into Day Care." *Pediatrics*, 94: 1059-1061; December 1994.
- Safer, D., & Krager, J. "Hyperactivity and Inattentiveness; School Assessment of Stimulant Treatment." *Clinical Pediatrics*, 89: 216-221; May 1989.
- Salkever, D. "Child Health and Other Determinants of Single Mothers' Labor Supply and Earnings." *Research in Human Capital and Development*, 6: 147-181; 1990.
- Salkever, D. "Children's Health Problems: Implications for Parental Labor Supply and Earnings." *National Bureau of Economic Research*, 283: 1982.
- Scholz, J. "The Earned Income Tax Credit: Participation, Compliance, and Antipoverty Effectiveness." *National Tax Journal*, 47: 65-72; March 1994.
- Scholz, J. "Tax Policy and the Working Poor: the Earned Income Tax Credit." *Focus*, University of Wisconsin-Madison, Institute for Research on Poverty, 3: Winter 1993-1994.
- Schor, E., & Chang, A. "Developmental Issues in Foster Care for Children." *Pediatrics*, 91: 1007-1009; May 1993.
- Schor, E., & Erickson, C. "Health Care of Children in Foster Care." *Pediatrics*, 93: 335-338; February 1994.
- Scott, C. "SSI Case Closures; Supplemental Security Income Program." *Social Security Bulletin*, 5(4): 5; December 1992.

Appendix 4-B

- Shakelford, J. "State Jurisdiction Eligibility Definitions for Part H." *NEC*TAS Notes*; February 1995.
- Shonkoff, J., & Hauser-Cram, P. "Early Intervention for Disabled Infants and Their Families: A Quantitative Analysis." *Pediatrics*, 80: 650-658; November 1987.
- Silverstein, K., & Cockburn, A. "How Rich Journalists Stole Crutches from Crippled Children." *CounterPunch*, July 1995.
- Smith, S. "National Center for Health Statistics Data Line." *Public Health Reports*, 108: 138-139; January 1993.
- Turnbull, H., Garlow, J., & Barber, P. "A Policy Analysis of Family Support for Families with Members with Disabilities." *Kansas Law Review*, 39(3): 739-782; 1991.
- "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review*, 53: 941-73; 1963.
- Weaver, C. "Welfare Payments to the Disabled: Making America Sick?" *The American Enterprise*, January/February 1995.
- Wolraich, M., Siperstein, G., & O'Keefe, P. "Pediatricians' Perceptions of Mentally Retarded Individuals." *Pediatrics*, 80: 643-649; November 1987.
- Yeargin-Allsopp, M., & Murphy, C. "A Multiple-Source Method for Studying the Prevalence of Developmental Disabilities in Children." *Pediatrics*, 89: 624-630; April 1992.

Newspaper Articles

"A 'Contract' Target: Disabled Kids." *The Philadelphia Daily News*: March 7, 1995.

Best, K., & Brasch Librach, P. "Disability Aid for Children: GOP Targets 'Spoiled Brats;' Congress Considers Reform Aimed at Fraud, Lack of Accountability." *St. Louis Post-Dispatch*: June 11, 1995.

Bradsher, K. "Low Ranking for Poor American Children: U.S. Youth Among Worst Off in Study of 18 Industrialized Nations." *New York Times*: August 14, 1995.

Burrell, S. "Children with Disabilities Aren't Cheaters." *Los Angeles Times*: January 13, 1995.

Devroy, A. "Administration Drops State Competition Idea From Social Security Plan." *The Washington Post*: April 13, 1995.

"Dissing the Disabled: A Plan to Cut Federal Aid to Disabled Kids is Based on False Ideas of Systematic Abuse." *The Philadelphia Inquirer* (p. A8): February 20, 1995.

Dixon, J. "Congress Likely to Cut Thousands of Children Off Disability Rolls." *The Washington Post*: June 8, 1995.

Dole, B. "Preserving the Purpose of Children's SSI (Opinion Editorial)." *The Washington Post* (p. A16): June 17, 1995.

"Don't Ban Cash Payments for Disabled Kids." *The Berkshire Eagle* (p. A8): January 29, 1995.

Dribben, M. "Tales of Fraud Imperil Children." *The Philadelphia Inquirer*: March 6, 1995.

"Expert Group Recommends Steps to Restructure Supplemental Security Disability Program for Children, Adolescents; In Response to Ways and Means Committee Request for Study, Nonpartisan Group Says Fraud Charges in Program are Unsubstantiated, Calls for Family Preservation, Change in Eligibility Requirements." *PR Newswire Association, Inc.*: May 8, 1995.

Flannery, M. "Breathing Room: Would Loss of SSI Fund Devastate Disabled Poor?" *The Philadelphia Daily News*: March 15, 1995.

Hargrove, T. "Misuse of Aid to Learning-Disabled Children Alleged." *The Atlanta Constitution*: December 30, 1994.

Appendix 4-C

- Jones, R. "Aid to Children With Mental Disabilities Finds GOP Support." *Philadelphia Inquirer*: May 28, 1995.
- Jouzaitis, C. "Despite Successes, Aid For Disabled Draws Fire; Congress Looks to Cut Assistance Program." *Chicago Tribune*: April 16, 1995.
- MacDonald, H. "Teaching Johnny to Fail: the Mixed-up Messages of Disability Welfare for Troubled Kids." *The Washington Post* (p. C7): June 18, 1995.
- O'Donnell, J. "Children are Coached to Get Aid, Social Security Admits: Estimate is 1%-2% of Cases Annually." *The Baltimore Sun*: April 8, 1995.
- O'Donnell, J. "'Coached' Children Wrongly Get Benefits: Arkansas SSI Official Says Many Aren't Really Disabled." *The Baltimore Sun*: March 11, 1995.
- O'Donnell, J. "Panel Would Revamp Aid to Disabled Children: Clinton Committee Would Drop 100,000 Children Over 5 Years." *The Baltimore Sun*: September 14, 1995.
- O'Donnell, J. "Senate May Soften Blow to SSI Passed By House: Debate to Focus on Disabled Youths." *The Baltimore Sun* (p. 1A): May 21, 1995.
- O'Donnell, J. "SSI Discourages Parental Aid of Children, Doctors Say." *The Baltimore Sun*: March 28, 1995.
- "Panel: Fund Disabled Children." *Associated Press*: May 7, 1995.
- "Replacing a Kill With a Cure." *The Washington Post*: June 7, 1995.
- Rich, S. "GOP Plan for Disabled Children Draws Fire." *The Washington Post*: February 25, 1995.
- Rich, S. "House Panel Votes to Curtail Program for Disabled Children." *The Washington Post* (p. A4): March 7, 1995.
- Ross, S. "Disability Insurance Program Needs Revision." *The Washington Post*: July 18, 1995.
- Slattery, J. "Keep the Cash." *The Washington Post*: July 12, 1995.
- "Special Report: The Disabling of America." *The Baltimore Sun*: January 22-23, 1995.
- "SSI Hearing Scheduled for Next Monday in City." *The Philadelphia Inquirer*: March 20, 1995.

Appendix 4-C

"Study Finds SSI Keeps Kids at Home." *The Washington Times*: May 8, 1995.

"Study: SSI Cuts 'Neither Necessary Nor Practical.'" *National Journal's Congress Daily*: May 8, 1995.

"The Attack on Disabled Children." *New York Times*: June 7, 1995.

Tousignant, M. "Children's Cure or Adults' Crutch?" *The Washington Post*: April 11, 1995.

Vobejda, B. "Abortions, Out-of-Wedlock Births Targeted: House Republicans Propose State Bonuses for Reductions." *The Washington Post*: March 1, 1995.

Vobejda, B. "Disabled People See Budget-Cutting Fervor as Threat, New Attitude." *The Washington Post*: August 3, 1995.

Wetzstein, C. "Welfare Panel Told Status Quo Must Go: Fewer Kids Seen Suffering with Reform." *The Washington Times*: April 28, 1995.

Williams, W. "Crazy Money's Side Effects." *The Washington Times*: July 12, 1995.

Reports and Working Papers

Reports

Aron, L., Loprest, P., & Steuerle, C. *Government Programs for Children With Disabilities Part I: Size, Participation, Benefits, and Expenditures* (Draft Final Report). The Urban Institute, February 1995.

Aron, L., Loprest, P., & Steuerle, C. *Systematic Thinking About Government Programs for Children with Disabilities Part II: Difficult Choices* (Draft Final Report). The Urban Institute, March 1995.

Burkhauser, R. & Glenn, A. *Empirical Sketches of How Changes in the Earned Income Tax Credit Could Increase the Economic Well-being of People with Disabilities*. National Academy of Social Insurance, March 1995.

Burkhauser, R., & Glenn, A. *Public Policies for the Working Poor: the Earned Income Tax Credit Versus Minimum Wage Legislation*. Center for Policy Research, Syracuse University, Spring 1994.

Cedarbaum, Jonathan G. *Policies for Children with Disabilities: Connecticut, Virginia, and Some National Trends*. Washington, D.C.: National Academy of Social Insurance, January 1995.

Committee on Ways and Means, U.S. House of Representatives. *Overview of Entitlement Programs*. July 15, 1994.

Congressional Budget Office. *The Costs of Administering Selected Poverty-Related Programs*. October 26, 1993.

Congressional Research Service. *Medicaid Source Book: Background Data and Analysis*. 1993 Update.

Degener, T. *Personal Assistant Service Programs in Germany, Sweden, and the U.S.A., Differences and Similarities*. Oakland, California: World Institute on Disability, March 1992.

Department of Agriculture. *Electronic Benefit Transfer in the Food Stamp Program: the First Decade*. March 1992.

Department of Agriculture. *The Evaluation of the Expanded EBT Demonstration in Maryland, Summary of Findings*. May 1994.

Appendix 4-D

- Department of Agriculture. *Managing for the Public Trust: Fiscal Year 1995 Activities to Increase Food Stamp Program Integrity*. February 1995.
- Department of Health, Education, and Welfare. *Health Services for Mentally Retarded Children: A Progress Report 1956-1960*. 1961.
- Department of Health and Human Services. "Better Health for Our Children: A National Strategy." *Report of the Select Panel for the Promotion of Child Health*. 1981.
- Department of Health and Human Services Office of Inspector General. *Concerns About the Participation of Children with Disabilities in the Supplemental Security Income Program*. October 1994.
- Department of Health and Human Services Office of Inspector General. *Reviews of the Participation of Children with Mental Disabilities in the Supplemental Security Income Program*. February 1995.
- Department of Health and Human Services Office of Inspector General. *Supplemental Security Income: Disability Determinations for Children With Mental Impairments*. January 1995.
- Department of Health and Human Services Office of Inspector General. *Supplemental Security Income: Medicaid Services Provided to Children with Mental Impairments*. March 1995.
- Department of Housing and Urban Development. *Section VIII Administrative Fees: A Report to Congress*. January 1994.
- Department of Housing and Urban Development. *Section VIII Administrative Fees: A Report to Congress*. June 1994.
- Duncan, B., & Brown, S. (Eds.) *Personal Assistance Services in Europe and North America*. Oakland, California: World Institute on Disability, 1993.
- Ellwood, M. *SSI-Related Disabled Children and Medicaid*. Systemetrics/McGraw-Hill, 1990.
- Ellwood, M., & Herz, E. *Longitudinal Analysis of High Cost Medicaid Children in California*. Systemetrics/McGraw-Hill, 1990.
- Egley, L. *Program Models Providing Personal Assistance Services (PAS) for Independent Living*. Oakland, California: World Institute on Disability, May 1994.

Appendix 4-D

- Food Marketing Institute. *Electronic Benefits Transfer White Paper*. Washington, D.C.: March 1993.
- Fox, H., & Greaney, A. *A Preliminary Assessment of Disabled Children's Access to Supplemental Security Income and Medicaid Benefits*. Washington, D.C.: Fox Health Policy Consultants, 1988.
- Fox, H., & Wicks, L. *Medicaid Financing for Mental Health and Substance Abuse Prevention and Treatment Services for Children and Adolescents*. Washington, D.C.: Fox Health Policy Consultants, 1990.
- Fox, H., & Wicks, L. *State Implementation of the OBRA '89 EPSDT Amendments*. Washington, D.C.: Fox Health Policy Consultants, 1991.
- Fox, H., & Wicks, L. *Using Medicaid to Finance Care Coordination Services for Children with Special Health Care Needs*. Washington, D.C.: Fox Health Policy Consultants, 1991.
- General Accounting Office. *Home Care Experiences of Families with Chronically Ill Children*. Washington, D.C., 1989.
- General Accounting Office. *Potential Impacts of Alternative Systems for Delivering Food Stamp Program Benefits*. December 1994.
- General Accounting Office. *Social Security: New Functional Assessments for Children Raise Eligibility Questions*. March 1995.
- General Accounting Office. *Social Security: Rapid Rise in Children on SSI Disability Rolls Follows New Regulations*. September 1994.
- Health Care Financing Administration. *Medicaid spData System; Characteristics of Medicaid State Programs*. Baltimore, Maryland, December 1993.
- Health Care Financing Administration. *Medicaid Statistics*. Baltimore, Maryland, 1994.
- Human Services Research Institute. *Supplemental Security Income for Children with Disabilities: an Exploration of Child and Family Needs and the Relative Merits of the Cash Benefit Program*. May 1995.
- Joint Committee on Taxation. *Description and Analysis of Proposals to Replace the Federal Income Tax*. June 5, 1995.

Appendix 4-D

- Joint Committee on Taxation. *Description of Present Law and Discussion of Issues Relating to the Earned Income Tax Credit*. June 14, 1995.
- Katz-Leavey, J., & Lourie, I. *Individualized Services in a System of Care*. Washington, D.C.: Georgetown University Child Development Center, 1992.
- Knapp, S. *An Analysis of the Service and Support Needs of Children with Severe and Chronic Disabilities (Unpublished Report Prepared for the National Commission on Childhood Disability)*. July 18, 1995.
- Leyser, B., & Blong, A. *The Use of Electronic Benefit Transfer Systems to Deliver Federal and State Assistance Benefits*. Center on Social Welfare Policy and Law, May 1993.
- Maxfield, M., Jr., & Kendall, A. *Disabled Children in the Supplemental Security Income Program*. June 30, 1981.
- National Academy of Social Insurance. *Disabled Worker Tax Credit*. June 1995.
- Proskaver, M. *Legislative History of the Supplemental Security Income (SSI) Program: 1969-1972*. Washington, D.C.: Congressional Research Service, March 11, 1977.
- Rivera, L., Regan, C., & Rosenbaum, S. *Managed Care and Children's Health: An Analysis of Early and Periodic, Diagnostic, and Treatment Services Under State Medicaid Managed Care Contracts*. Washington, D.C.: The Children's Defense Fund, 1995.
- Social Security Administration. *Children Receiving SSI*. December 1994 and June 1995.
- Social Security Administration. *Findings from the Study of Title XVI Childhood Disability Claims*. May 1994.
- Social Security Administration. *Social Security Administration 1994 Annual Report to the Congress*. July 1994.
- Social Security Administration. *Study of SSI Recipients in Multi-Recipient Households*. March 1994.
- Stapleton, D. *An Exploratory Study of Barriers and Incentives to Improving Labor Force Participation Among Persons with Significant Disabilities*. Department of Health and Human Services, June 30, 1995.

Appendix 4-D

Stroul, B. *Series on Community-based Services for Children and Adolescents Who Are Severely Emotionally Disturbed*. Washington, D.C.: Georgetown University Child Development Center, 1989.

Stroul, B. *Systems of Care for Children and Adolescents with Severe Emotional Disturbances: What are the Results?* Washington, D.C.: Georgetown University Child Development Center, 1993.

Stroul, B., & Katz-Leavey, J. *Systems of Care for Children and Adolescents with Severe Emotional Disturbances*. Washington, D.C.: Georgetown University Child Development Center, 1992.

Weissman, J., Kennedy, J., & Litvak, S. (Eds.) *Personal Perspectives on Personal Assistant Services*. Oakland, California: World Institute on Disability, September 1992.

World Institute on Disability. *Attending to America: Personal Assistance for Independent Living. A Survey of Attendant Service Programs in the United States for People of All Ages with Disabilities*. Berkeley, California: April 1987.

Appendix 4-D

Working Papers

Adler, M. *Expenditure Patterns for Families Receiving SSI: 1988-1993*. Department of Health and Human Services. May 1995.

Burkhauser, R., & Glenn, A. *Empirical Sketches of How Changes in the Earned Income Tax Credit Could Increase the Economic Well-Being of People With Disabilities*. Vanderbilt University, March 1995.

General Pediatric Research Unit, Massachusetts General Hospital, Harvard Medical School. *Changes in Supplemental Security Income for Children and Adolescents* (Progress Report). May 1995.

Institute for Child Health Policy. *Role of Title V and SSI Institute for Child Health Policy*. June 1995.

National Academy of Social Insurance. *Background Paper for Children's Committee for the Disability Policy Panel SSI Eligibility Criteria for Childhood Mental Disorders*. March 1995.

Reno, V. *Focus Group Qualitative Results: Preliminary Report for the Disability Policy Panel*. November 1994.

Social Security Administration Guides and Pamphlets

A Guide for Representative Payees: Social Security and SSI. SSA publication number 05-10076, June 1994.

Childhood Disability Under the Childhood Disability Supplemental Security Income Program: A Guide for Physicians and Other Health Professionals. SSA publication number 64-048, July 1994.

Disability Evaluation Under Social Security. SSA publication number 64-039, January 1995.

Program Operations Manual System, Part 4, Chapter 252: Title XVI Child Claims Based on Disability. SSA publication number 68-0425200, November 1993.

Red Book on Work Incentives—A Summary Guide to Social Security and Supplemental Security Income Work Incentives for People With Disabilities. SSA publication number 64-030, August 1994.

Social Security and SSI Benefits for Children With Disabilities. SSA publication number 05-10026, January 1993.

SSI in Pennsylvania: a Factsheet from Social Security. SSA publication number 05-11150, January 1995.

Title XVI Childhood Disability Evaluation: Changes in the Final Regulations. Childhood Disability Under the Childhood Disability Supplemental Security Income Program: A Guide for School Professionals. SSA publication number 64-049, July 1994.

Training Guide: Title XVI Childhood Disability Claims. SSA publication number 64-051, June 1994.

Working While Disabled—A Guide to Plans for Achieving Self-Support While Receiving Supplemental Security Income. SSA publication number 05-11017, August 1991.

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

SULLIVAN, SECRETARY OF HEALTH AND HUMAN SERVICES *v.* ZEBLEY ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 88-1377. Argued November 28, 1989—Decided February 20, 1990

The Social Security Act authorizes the payment of Supplemental Security Income (SSI) benefits to, *inter alios*, a child who suffers from an impairment of "comparable severity" to one that would render an adult disabled. An adult is disabled if he is prevented from engaging in any *substantial* gainful activity by reason of certain medically determinable physical or mental impairments. Petitioner Secretary of Health and Human Services has created a 5-step test to determine *adult* disability. At the test's third step, a claimant may be found to be disabled if medical evidence of his impairment matches or is equal to one of a listing of impairments presumed severe enough to preclude *any* gainful activity, thus making further inquiry unnecessary. However, since the listings' medical criteria are more restrictive than the statutory disability standard, an adult claimant who does not qualify at the third step may do so after showing, at the fourth and fifth steps, that he cannot engage in his past work or other work in the economy, given his age, education, and work experience. In contrast, the Secretary's test for determining whether a *child* claimant is disabled ends if the claimant cannot show that his impairment matches or is equal to a listed impairment, there being no further inquiry corresponding to the final, vocational steps of the adult test. Respondent Zebley, a child who was denied SSI benefits, brought a class action in the District Court challenging the child-disability regulations. The court granted summary judgment for the Secretary. The Court of Appeals vacated the judgment in part, finding the regulatory scheme to be inconsistent with the Act, because the listings-only approach does not account for all impairments of "comparable severity," and denies child claimants the individualized functional assess-

Syllabus

ment that the statutory standard requires and that the Secretary provides to adults.

Held: The child-disability regulations are inconsistent with the statutory standard of "comparable severity." Pp. 5-18.

(a) While adults who do not qualify under the listings still have the opportunity to show that they are disabled at the last steps of the Secretary's test, no similar opportunity exists for children, who are denied benefits even if their impairments are of "comparable severity" to ones that would actually (though not presumptively) disable adults. Pp. 7-13.

(b) The Secretary's regulatory scheme—which applies the same approach to child-disability claimants and to claimants for widows' and widowers' Social Security disability benefits, despite the fact that the Act uses a stricter standard for widows' benefits—nullifies the congressional choice to link the child-disability standard to the more liberal test applied to adult disability claims. Pp. 14-15.

(c) The Secretary's argument that the listings-only approach is the only practicable way to determine whether a child's impairment is comparable to one that would disable an adult is rejected. Even if they were set at the statutory level of severity, no set of listings could ensure that child claimants would receive benefits whenever their impairments are of comparable severity to ones that would qualify an adult for benefits under the individualized functional analysis contemplated by the statute and provided to adults. That a vocational analysis is inapplicable to children does not mean that a *functional* analysis cannot be applied to them, since an inquiry into an impairment's impact on a child's normal daily activities is no more amorphous or unmanageable than an inquiry into the impact of an adult's impairment on his ability to perform any kind of substantial gainful work that exists in the economy. Moreover, the Secretary tacitly acknowledges that functional assessment of child claimants is possible in that some of his own listings are defined in terms of functional criteria, and the test for cessation of disability involves an examination of a child claimant's ability to perform age-appropriate activities. Pp. 16-18.

855 F. 2d 67, affirmed.

BLACKMUN, J., delivered the opinion of the Court, in which BRENNAN, MARSHALL STEVENS, O'CONNOR, SCALIA, and KENNEDY, JJ., joined. WHITE, J., filed a dissenting opinion, in which REHNQUIST, C. J., joined.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER *v.*
BRIAN ZEBLEY ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE THIRD CIRCUIT

[February 20, 1990]

JUSTICE BLACKMUN delivered the opinion of the Court.

This case concerns a facial challenge to the method used by the Secretary of Health and Human Services to determine whether a child is “disabled,” and therefore eligible for benefits under the Supplemental Security Income Program, Title XVI of the Social Security Act, as added, 86 Stat. 1465, and amended, 42 U. S. C. § 1381 *et seq.* (1982 ed. and Supp. V).

I

In 1972, Congress enacted the Supplemental Security Income Program (SSI) to assist “individuals who have attained age 65 or are blind or disabled” by setting a guaranteed minimum income level for such persons. 42 U. S. C. § 1381. The program went into effect January 1, 1974. Currently, about 2,000,000 claims for SSI benefits are adjudicated each year. Of these, about 100,000 are child-disability claims.¹

A person is eligible for SSI benefits if his income and financial resources are below a certain level, § 1382(a), and if he is “disabled.” Disability is defined in § 1382c(a)(3) as follows:

“(A) An individual shall be considered to be disabled for purposes of this subchapter if he is unable to engage in

¹ Social Security Administration, Office of Disability, Preliminary Staff Report: Childhood Disability Study, p. B-1 (Sept. 20, 1989).

88-1377-OPINION

2

SULLIVAN v. ZEBLEY

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 twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

"(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy

"(C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques."

This statutory definition of disability was taken from Title II of the Social Security Act, 42 U. S. C. § 423 *et seq.*, as amended (providing for payment of insurance benefits to disabled workers who have contributed to the Social Security Program). See §§ 423(d)(1)(A) and (2)(A) (definitions of disability).

Pursuant to his statutory authority to implement the SSI Program,² the Secretary has promulgated regulations creating a 5-step test to determine whether an *adult* claimant is

²42 U. S. C. § 405(a), made applicable to Title XVI by § 1383(d)(1), reads:

"The Secretary shall have full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and shall adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence . . . in order to establish the right to benefits hereunder."

88-1377—OPINION

SULLIVAN *v.* ZEBLEY

3

disabled. See *Bowen v. Yuckert*, 482 U. S. 137, 140–142 (1987).⁴ The first two steps involve threshold determinations that the claimant is not presently working, and has an impairment which is of the required duration and which significantly limits his ability to work. See 20 CFR §§ 416.920(a) through (c) (1989). In the third step, the medical evidence of the claimant's impairment is compared to a list of impairments presumed severe enough to preclude any gainful work. See 20 CFR pt. 404, subpt. P, App. 1 (pt. A) (1989). If the claimant's impairment matches or is "equal" to one of the listed impairments, he qualifies for benefits without further inquiry. § 416.920(d). If the claimant cannot qualify under the listings, the analysis proceeds to the fourth and fifth steps. At these steps, the inquiry is whether the claimant can do his own past work or any other work that exists in the national economy, in view of his age, education, and work experience. If the claimant cannot do his past work or other work, he qualifies for benefits. §§ 416.920(e) and (f).

The Secretary's test for determining whether a *child* claimant is disabled is an abbreviated version of the adult test. A child qualifies for benefits if he "is not doing any substantial gainful activity," § 416.924(a), if his impairment meets the duration requirement, § 416.924(b)(1), and if it matches or is medically equal to a listed impairment, §§ 416.924(b)(2) and (3). In evaluating a child's claim, both the general listings and a special listing of children's impairments, 20 CFR pt. 404, subpt. P, App. 1 (pt. B), are considered. If a child cannot qualify under these listings, he is denied benefits. There is no further inquiry corresponding to the fourth and fifth steps of the adult test.

⁴The regulations implementing the Title II disability standard, 42 U. S. C. § 423(d), at issue in *Yuckert*, and those implementing the identical Title XVI standard, § 1382c(a)(3), at issue in this case, are the same in all relevant respects. Compare 20 CFR §§ 404.1520–1530 with §§ 416.920–930 (1989).

88-1877—OPINION

4

SULLIVAN *v.* ZEBLEY

II

Respondent Brian Zebley, a child who had been denied SSI benefits, brought a class action in the United States District Court for the Eastern District of Pennsylvania to challenge the child-disability regulations.⁴ His complaint alleges that the Secretary

"has promulgated regulations and issued instructions . . . whereby children have their entitlement to SSI disability benefits based solely on the grounds that they have a listed impairment or the medical equivalent of a listed impairment . . . in contravention of the Act's requirement that a child be considered disabled 'if he suffers from any medically determinable physical or mental impairment of comparable severity' to that which disables an adult under the program."

Complaint in ED Pa. Civil Action No. 83-3314, ¶2. The District Court, on January 10, 1984, certified a class of all persons "who are now, or who in the future will be, entitled to an administrative determination . . . as to whether supplemental security income benefits are payable on account of a child who is disabled, or as to whether such benefits have been improperly denied, or improperly terminated, or should be resumed."

The court in due course granted summary judgment in the Secretary's favor as to the class claims, ruling that the regulations are not "facially invalid or incomplete . . . and permit[t] the award of benefits in conformity with the intent of Congress." *Zebley v. Heckler*, 642 F. Supp. 220, 222 (1986). The Court of Appeals for the Third Circuit vacated in part that summary judgment. *Zebley ex rel. Zebley v. Bowen*,

⁴ Respondents Joseph Love and Evelyn Ranshi, two children who were denied benefits, are the other two named plaintiffs in this action. All three named plaintiffs' individual claims were eventually remanded to the Secretary by the District Court; only the class claims remain before this Court.

88-1377—OPINION

SULLIVAN *vs.* ZEBLEY

5

855 F. 2d 67 (1988). The Third Circuit found the Secretary's regulatory scheme for child disability benefits inconsistent with the statute, because the listings-only approach of the regulations does not account for all impairments of "comparable severity," and denies child claimants the individualized functional assessment that the statutory standard requires and that the Secretary provides to adults. *Id.*, at 69. Although the Court of Appeals recognized that the Secretary's interpretation of the statute is entitled to deference, it rejected the regulations as contrary to clear congressional intent. The court remanded the case to the District Court with the direction that summary judgment be entered in favor of the plaintiff class on the claim that the Secretary must give child claimants an opportunity for individualized assessment of their functional limitations. *Id.*, at 77. We granted certiorari to resolve a conflict among the Circuits as to the validity of the Secretary's approach to child disability.⁵

III

Since the Social Security Act expressly grants the Secretary rulemaking power, see n. 2, *supra*, "our review is limited to determining whether the regulations promulgated exceeded the Secretary's statutory authority and whether they are arbitrary and capricious." *Bowen v. Yuckert*, 482 U. S., at 145 (quoting *Heckler v. Campbell*, 461 U. S. 458, 466 (1983)); see *Chevron U. S. A., Inc. v. Natural Resources*

⁵The First and Eleventh Circuits have upheld the validity of the Secretary's approach to child disability. *Hinckley ex rel. Martin v. Secretary of Health and Human Services*, 742 F. 2d 19 (CA1 1984); *Powell ex rel. Powell v. Schweiker*, 688 F. 2d 1357 (CA11 1982). Also, the Fifth and Eighth Circuits have ruled that the Secretary properly applied the child-disability regulations to deny benefits in a particular case, without explicitly addressing the question whether the regulations are valid. *Nash ex rel. Alexander v. Bowen*, 882 F. 2d 1291 (CA8 1989); *Burnside ex rel. Burnside v. Bowen*, 845 F. 2d 587 (CA5 1988). The Third Circuit in the present case acknowledged the conflict. *Zebley ex rel. Zebley v. Bowen*, 855 F. 2d 67, 75 (1988).

88-1377—OPINION

Defense Council, Inc., 467 U. S. 837, 843-844 (1984) ("If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute"). We conclude, however, that the Secretary's child-disability regulations cannot be reconciled with the statute they purport to implement.

The statute generally defines "disability" in terms of an individualized, functional inquiry into the effect of medical problems on a person's ability to work. *Yuckert*, 482 U. S., at 146 (Social Security Act adopts "functional approach"); *Campbell*, 461 U. S., at 459-460, 467 (Act "defines 'disability' in terms of the effect a physical or mental impairment has on a person's ability to function in the workplace"; "statutory scheme contemplates that disability hearings will be individualized determinations").

The statutory standard for child disability is explicitly linked to this functional, individualized standard for adult disability. A child is considered to be disabled "if he suffers from any . . . impairment of comparable severity" to one that would render an adult "unable to engage in any substantial gainful activity." 42 U. S. C. § 1382c(a)(3)(A). The next paragraph of the statute elaborates on the adult disability standard, providing that an adult is considered unable to engage in substantial gainful activity, and is therefore disabled, if he is unable to do either his own past work or other work. § 1382c(a)(3)(B). In plain words, the two provisions together mean that a child is entitled to benefits if his impairment is as severe as one that would prevent an adult from working.

The question presented is whether the Secretary's method of determining child disability conforms to this statutory standard. Respondents argue, and the Third Circuit agreed, that it does not, because the regulatory requirement that a child claimant's impairment must match or be equiva-

88-1377—OPINION

SULLIVAN *v.* ZEBLEY

7

lent to a listed impairment denies benefits to those children whose impairments are severe and disabling even though the impairments are not listed and cannot meaningfully be compared with the listings. The Secretary concedes that his listings do not cover every impairment that could qualify a child for benefits under the statutory standard, but insists that the listings, together with the equivalence determination, see 20 CFR § 416.924(b)(3), are sufficient to carry out the statutory mandate that children with impairments of "comparable severity" shall be considered disabled. To decide this question, we must take a closer look at the regulations at issue.

IV

The listings set out at 20 CFR pt. 404, subpt. P, App. I (pt. A), are descriptions of various physical and mental illnesses and abnormalities, most of which are categorized by the body system they affect.⁶ Each impairment is defined in terms of several specific medical signs, symptoms, or laboratory test results.⁷ For a claimant to show that his impairment

⁶There are 125 impairments defined in the adult listings, and an additional 57 in the child listings. The body system categories in the adult listings are: musculoskeletal, special senses and speech, respiratory, cardiovascular, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine. In addition, there are four groups of listings not categorized by body system: multiple body system impairments, neurological impairments, mental disorders, and malignant neoplastic diseases. The child-disability listings include, in addition to all these, a category for growth impairment.

⁷For example, under the "growth impairment" category of the child-disability listings, 20 CFR pt. 404, subpt. P, App. I (pt. B) § 100, there is a listing the medical criteria of which require the claimant to show both a "[f]all of greater than 25 percentiles in height which is sustained" and "[b]one age greater than two standard deviations . . . below the mean for chronological age." § 100.03. Another example is the listing for "mental retardation," which requires that a child claimant show "[a]chievement of only those developmental milestones generally acquired by children no more than one-half the child's chronological age," or "IQ of 59 or less," or "IQ of 60-69, inclusive, and a physical or other mental impairment im-

88-1377-OPINION

8

SULLIVAN *v.* ZEBLEY

matches a listing, it must meet *all* of the specified medical criteria. An impairment that manifests only some of those criteria, no matter how severely, does not qualify.⁸ See Social Security Ruling (SSR) 83-19,⁹ West's Social Security Reporting Service (Rulings Supp. Pamph. 1988) 90, 91-92 ("An impairment 'meets' a listed condition . . . only when it manifests the specific findings described in the set of medical criteria for that listed impairment The level of severity in any particular listing section is depicted by the *given set* of findings and not by the degree of severity of any single medical finding—no matter to what extent that finding may exceed the listed value") (emphasis in original).

For a claimant to qualify for benefits by showing that his unlisted impairment, or combination of impairments, is "equivalent" to a listed impairment, he must present medical findings equal in severity to *all* the criteria for the one most similar listed impairment.¹⁰ 20 CFR §416.926(a) (a claimant's impairment is "equivalent" to a listed impairment "if the medical findings are at least equal in severity" to the medical criteria for "the listed impairment most like [the claimant's] impairment"); SSR 83-19, at 92 (a claimant's impairment is "equivalent" to a listing only if his symptoms,

posing additional and significant restriction of function or developmental progression." §112.05.

⁸For example, in the growth impairment listing described in n. 7, *supra*, a child claimant whose "bone age" was slightly less than two standard deviations below normal would not qualify under the listing, even if his height was much more than 25 percentiles below normal.

⁹Social Security Rulings are agency rulings "published under the authority of the Commissioner of Social Security and are binding on all components of the Administration." 20 CFR §422.408 (1989); see *Heckler v. Edwards*, 465 U. S. 870, 873, n. 3 (1984).

¹⁰For example, a child claimant with Down syndrome (which currently is not a listed impairment), a congenital disorder usually manifested by mental retardation, skeletal deformity and cardiovascular and digestive problems, would have to fulfill the criteria for whichever single listing his condition most resembled. See Brief for National Easter Seal Society, *et al.*, as *Amici Curiae* 17, n. 9.

88-1377—OPINION

SULLIVAN *v.* ZEBLEY

9

signs, and laboratory findings are “at least equivalent in severity to” the criteria for “the listed impairment most like the individual’s impairment(s)”; when a person has a combination of impairments, “the medical findings of the combined impairments will be compared to the findings of the listed impairment most similar to the individual’s most severe impairment”).¹² A claimant cannot qualify for benefits under the “equivalence” step by showing that the overall functional impact of his unlisted impairment or combination of impairments is as severe as that of a listed impairment. SSR 83-19, at 92-93 (“it is incorrect to consider whether the listing is equaled on the basis of an assessment of *overall* functional impairment The functional consequences of the impairments . . . irrespective of their nature or extent, *cannot* justify a determination of equivalence”) (emphases in original).

The Secretary explicitly has set the medical criteria defining the listed impairments at a higher level of severity than the statutory standard. The listings define impairments that would prevent an adult, regardless of his age, education, or work experience, from performing *any* gainful activity, not just “substantial gainful activity.” See 20 CFR § 416.925(a) (purpose of listings is to describe impairments “severe enough to prevent a person from doing any gainful activity”); SSR 83-19, at 91 (listings define “medical conditions which ordinarily prevent an individual from engaging in any gainful activity”). The reason for this difference between the listings’ level of severity and the statutory standard is that, for adults, the listings were designed to operate as a presumption of disability that makes further inquiry unnecessary. That is, if an adult is not actually working and

¹² For example, if a child has both a growth impairment slightly less severe than required by listing § 100.03, and is mentally retarded but has an IQ just above the cut-off level set by § 112.04, he cannot qualify for benefits under the “equivalence” analysis—no matter how devastating the combined impact of mental retardation and impaired physical growth.

88-1377—OPINION

10

SULLIVAN *a* ZEBLEY

his impairment matches or is equivalent to a listed impairment, he is presumed unable to work, and is awarded benefits without a determination whether he actually can perform his own prior work or other work. See *Yuckert*, 482 U. S., at 141 (if an adult's impairment "meets or equals one of the listed impairments, the claimant is conclusively presumed to be disabled. If the impairment is not one that is conclusively presumed to be disabling, the evaluation proceeds to the fourth step"; the listings "streamlin[e] the decision process by identifying those claimants whose medical impairments are so severe that it is likely they would be found disabled regardless of their vocational background," *id.*, at 153); *Bowen v. City of New York*, 476 U. S. 467, 471 (1986) ("If a claimant's condition meets or equals the listed impairments, he is conclusively presumed to be disabled and entitled to benefits"; if not, "the process moves to the fourth step"); *Campbell*, 461 U. S., at 460 ("The regulations recognize that certain impairments are so severe that they prevent a person from pursuing any gainful work A claimant who establishes that he suffers from one of these impairments will be considered disabled without further inquiry If a claimant suffers from a less severe impairment, the Secretary must determine whether the claimant retains the ability to [work]").

When the Secretary developed the child-disability listings, he set their medical criteria at the same level of severity as that of the adult listings. See 42 Fed. Reg. 14705 (1977) (the child disability listings describe impairments "of 'comparable severity' to the adult listing"); SSA Disability Insurance Letter No. III-11² (Jan. 9, 1974), App. 97 (child-disability listings describe impairments that affect children "to the same extent as . . . the impairments listed in the adult criteria" affect adults' ability to work).

² A Disability Insurance Letter (DIL) is an internal directive sent by the Secretary to the state agencies responsible for disability determinations. See Brief for Petitioner 36.

88-1377—OPINION

SULLIVAN v. ZEBLEY

11

Thus, the listings in several ways are more restrictive than the statutory standard. First, the listings obviously do not cover all illnesses and abnormalities that actually can be disabling. The Secretary himself has characterized the adult listing as merely containing "over 100 *examples* of medical conditions which ordinarily prevent" a person from working, and has recognized that "it is difficult to include in the listing all the sets of medical findings which describe impairments severe enough to prevent any gainful work." SSR 83-19, at 91 (emphasis added). See also 50 Fed. Reg. 50068, 50069 (1985) (listings contain only the most "frequently diagnosed" impairments); 44 Fed. Reg. 18170, 18175 (1979) ("The Listing criteria are intended to identify the more commonly occurring impairments"). Similarly, when the Secretary published the child-disability listings for comment in 1977, he described them as including only the "more common impairments" affecting children. 42 Fed. Reg. 14706 (the child disability listings "provide a means to efficiently and equitably evaluate the more common impairments").²²

Second, even those medical conditions that are covered in the listings are defined by criteria setting a higher level of severity than the statutory standard, so they exclude claimants who have listed impairments in a form severe enough to preclude *substantial* gainful activity, but not quite severe enough to meet the listings level—that which would preclude *any* gainful activity. Third, the listings also exclude any claimant whose impairment would not prevent any and all persons from doing any kind of work, but which actually precludes the particular claimant from working, given

²²There are, as yet, no specific listings for many well-known childhood impairments, including spina bifida, Down syndrome, muscular dystrophy, autism, AIDS, infant drug dependency, and fetal alcohol syndrome. See Brief for American Medical Association, *et al.*, as *Amici Curiae* (AMA Brief) 22. The Secretary, however, has proposed new listings for "Down syndrome and other Hereditary, Congenital, and Acquired Disorders." 52 Fed. Reg. 37161 (1987). See Reply Brief for Petitioner 19, n. 16.

88-1377—OPINION

12

SULLIVAN *v.* ZEBLEY

its actual effects on him—such as pain, consequences of medication, and other symptoms that vary greatly with the individual¹⁴—and given the claimant's age, education, and work experience. Fourth, the equivalence analysis excludes claimants who have unlisted impairments, or combinations of impairments, that do not fulfill all the criteria for any one listed impairment. Thus, there are several obvious categories of claimants who would not qualify under the listings, but who nonetheless would meet the statutory standard.

For *adults*, these shortcomings of the listings are remedied at the final, vocational steps of the Secretary's test. A claimant who does not qualify for benefits under the listings, for any of the reasons described above, still has the opportunity to show that his impairment in fact prevents him from working. 20 CFR §§ 416.920(e) and (f); *Fuckert*, 482 U. S., at 141 (if an adult claimant's "impairment is not one that is conclusively presumed to be disabling, the evaluation proceeds" to the fourth and fifth steps); *Campbell*, 461 U. S., at 460 ("If a claimant suffers from a less severe impairment" than the listed impairments, "the Secretary must determine whether the claimant retains the ability to perform either his former work or some less demanding employment").¹⁵

For children, however, there is no similar opportunity. Children whose impairments are not quite severe enough to

¹⁴The Secretary has stated that the severity of perceived symptoms such as pain has no bearing on the determination whether a claimant's impairment meets or equals a listing. Social Security Ruling 82-58, DHHS Rulings, Cumulative Edition 1982, p. 121 ("No alleged or reported intensity of the symptoms can be substituted to elevate impairment severity to equivalency [C]omplaints of 'severe,' 'extreme,' or 'constant' pain will not compensate for . . . missing medical findings and permit an 'equals' determination") (emphasis deleted).

¹⁵About 25% of adult claimants qualify for benefits under steps four and five of the Secretary's test. House Committee on Ways and Means, Background Material and Data On Programs Within the Jurisdiction of the Committee on Ways and Means, 1989 Ed., 101st Cong., 1st Sess., 46 (Comm. Print).

88-1877—OPINION

SULLIVAN *vs.* ZERLEY

13

rise to the presumptively disabling level set by the listings; children with impairments that might not disable any and all children, but which actually disable *them*, due to symptomatic effects such as pain, nausea, side effects of medication, etc., or due to their particular age, educational background, and circumstances; and children with unlisted impairments or combinations of impairments¹⁸ that are not equivalent to any one listing—all these categories of child claimants are simply denied benefits, even if their impairments are of “comparable severity” to ones that would actually (though not presumptively) render an adult disabled.¹⁹

¹⁸ As the dissent points out, *post*, at 6–7, 42 U. S. C. § 1382c(a)(3)(F) requires that “the combined impact of [multiple] impairments shall be considered throughout the disability determination process,” and 20 CFR § 416.923 promises that “we will consider the combined effect of all your impairments.” This assurance may be of value to adult claimants, but not to children, for whom the combined effect of multiple impairments is considered *only* within the confines of the equivalence determination, “whether the combination of your impairments is medically equal to *any* listed impairment.” 20 CFR § 416.926(a). As the Court of Appeals noted, *if* children are afforded the individualized consideration given to adults, *then* § 416.923 would fulfill the statutory mandate as to children with multiple impairments. 865 F. 2d, at 76.

¹⁹ Empirical evidence suggests that the rigidity of the Secretary’s listings-only approach has a severe impact on child claimants. There are many rare childhood diseases that cannot meaningfully be compared with any of the listings. AMA Brief 6, 25 (it is unlikely “that any physician could make meaningful comparisons between extremely rare diseases and the set medical criteria listed by the Secretary”). Moreover, the listings-only approach disregards factors such as pain, side effects of medication, feeding problems, dependence on medical equipment, confinement at home, and frequent hospitalization, that vary with each individual case. A recent study suggests that children with multiple impairments, young children who cannot be subjected to the clinical tests required by the listings criteria, and children whose impairments have a severe functional impact but which do not match listings criteria, are often denied benefits. H. Fox & A. Greaney, *Disabled Children’s Access to Supplemental Security Income and Medicaid Benefits* (1988).

A telling example of the effect of the listings-only approach is found in *Wilkinson ex rel. Wilkinson v. Bowen*, 847 F. 2d 660 (CA11 1987) (child

88-1377—OPINION

14

SULLIVAN *vs.* ZEBLEY

The child-disability regulations are simply inconsistent with the statutory standard of “comparable severity.”¹³ This inconsistency is aptly illustrated by the fact that the Secretary applies the same approach to child-disability determinations under Title XVI and to widows’ and widowers’ disability benefits under Title II, despite the fact that Title II sets a stricter standard for widows’ benefits. Under the Secretary’s regulations and rulings, both widows and children qualify for benefits *only* if the medical evidence of their impairments meets or equals a listing. SSR 83-19, at 94. Title II provides: “A widow . . . or widower shall not be determined to be under a disability . . . unless his or her . . .

with rare liver disorder causing severe swelling, food allergies and fever, and requiring constant care and confinement at home, does not qualify for benefits because his impairment does not meet or equal the criteria for any listing); see also *Zebley ex rel. Zebley v. Bowen*, 855 F. 2d 67 (CA3 1988) (plaintiff Zebley denied benefits, despite evidence of congenital brain damage, mental retardation, development delay, eye problems and musculoskeletal impairment, because his condition did not meet or equal any listing).

The disparity in the Secretary’s treatment of child and adult claimants is thrown into sharp relief in cases where an unsuccessful child claimant, upon reaching age 18, is awarded benefits on the basis of the *same* impairment deemed insufficient to qualify him for child disability benefits. See, e. g., *Wills v. Secretary of Health and Human Services*, 686 F. Supp. 171, 172, and n. 1 (WD Mich. 1987); Brief of National Organization of Social Security Claimants’ Representatives as *Amicus Curiae*, A-3 to A-24 (ALJ decisions awarding benefits when child claimant turns 18). See also Tr. of Oral Arg. 13-14.

¹³The dissent proposes that children who fail to qualify for benefits under the Secretary’s current approach can simply “make their case before the Secretary, and take the case to court if their claims are rejected.” *Post*, at 4-5. We fail to see why each child denied benefits because his impairment falls within the several categories of impairments that meet the statutory standard but do not qualify under the Secretary’s listings-only approach, should be compelled to raise a separate, as-applied challenge to the regulations, or why a facial challenge is not a proper response to the systemic disparity between the statutory standard and the Secretary’s approach to child disability claims.

88-1377—OPINION

SULLIVAN *v.* ZEBLEY

15

impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity." 42 U. S. C. § 423(d)(2)(B). When Congress set out to provide disabled children with benefits, it chose to link the disability standard *not* to this test, but instead to the more liberal test set forth in § 423(d)(2)(A) and in § 1382c(a)(3)(A) (any impairment making a claimant "unable to engage in any substantial gainful activity" qualifies him for benefits). The Secretary's regulations, treating child-disability claims like claims for widows' benefits, nullify this congressional choice. See *Yuckert*, 482 U. S., at 163-164 (dissenting opinion) (contrasting widows' disability statute with the § 423(d)(2)(A)/§ 1382c(a)(3) test, which requires an individualized inquiry as to whether the claimant can work); S. Rep. No. 744, 90th Cong., 1st Sess., 49 (1967) (disabled widows' statutory "test of disability . . . is somewhat more restrictive than that for disabled workers")."

"The dissent, *post*, at 6, n. 2, appears to accept the Secretary's argument that Congress expressly indicated its approval of his approach to child disability in 1976, when it directed him to "publish criteria" to be employed to determine disability in children's cases. Unemployment Compensation Amendments of 1976, § 501(b), 90 Stat. 2683, 2685 (1976). At that time, however, Congress could not have known the exact contours of the Secretary's approach. Congress had before it only the Secretary's 1973 and 1974 DILs and accompanying "medical guides" that eventually became the child-disability listings, and the proposed regulations published for comment at 39 Fed. Reg. 1624 (1974).

The DILs are ambiguous as to the scope of the child disability determination. The 1973 DIL says that "childhood disability will be determined solely in consideration of medical factors," but it also says that "disability in children must be defined in terms of the primary activity in which they engage, namely growth and development," and that "[d]escriptions of a child's activities, behavioral adjustment, and school achievement may be considered in relationship to the overall medical history regarding severity of the impairment." SSA Disability Insurance Letter No. III-11 (1973), App. 90-91. The 1974 DIL does reflect the listings-only approach, but its discussion of the "equivalence" determination suggests a broader inquiry than the Secretary's present rules allow. SSA Disability Insurance Letter

88-1377—OPINION

16

SULLIVAN *v.* ZEBLEY

V

The Secretary does not seriously dispute the disparity in his approach to child and adult-disability determinations. He argues, instead, that the listings-only approach is the only practicable way to determine whether a child's impairment is "comparable" to one that would disable an adult. An individualized, functional approach to child-disability claims like that provided for adults is not feasible, the Secretary asserts, since children do not work; there is no available measure of their functional abilities analogous to an adult's ability to work, so the only way to measure "comparable severity" is to compare child claimants' medical evidence with the standard of severity set by the listings. Laying to one side the obvious point that such a comparison does not properly imple-

No. III-11, Supp. 1 (1974), App. 97 ("medical equivalency" concept . . . takes into account the particular effect of disease processes in childhood"; when used to evaluate multiple impairments, "[e]ach impairment must have some substantial adverse effect on the child's major daily activities, and together must 'equal' the specified impact"). Congress could not have guessed that these early directives would evolve into the present regulatory scheme.

Similarly, the 1974 proposed regulations provide that a child with an unlisted impairment qualifies for benefits if his impairment is "determined . . . with appropriate consideration of the particular effect of disease processes in childhood, to be medically the equivalent of a listed impairment." 39 Fed. Reg., at 1626. The regulation defining "medical equivalence" says only that an impairment is equivalent to a listed one "only if the medical findings with respect thereto are at least equivalent in severity and duration to the listing findings of the listed impairment." *Id.*; cf. 20 CFR § 416.926 (1989) (current definition of equivalence, requiring claimant to meet all criteria for the one most similar listed impairment). Thus, the proposed regulations gave little warning of the Secretary's current, strictly limited equivalence analysis. At least until SSR 83-19 was promulgated in 1983, it did not become clear that the listings criteria would be applied so rigidly, and that proof of equivalence would require a strict matching of the criteria for the single most similar listed impairment.

The 1976 directive to publish criteria therefore has little bearing on the question whether the Secretary's present approach to child disability is consistent with the statute.

88-1377—OPINION

SULLIVAN *v.* ZEBLEY

17

ment the statute because the Secretary's current listings set a level of severity higher than that prescribed by the statute, this argument still is not persuasive. Even if the listings were set at the same level of severity as the statute, and expanded to cover many more childhood impairments, no set of listings could ensure that child claimants would receive benefits whenever their impairments are of "comparable severity" to ones that would qualify an adult for benefits under the individualized, functional analysis contemplated by the statute and provided to adults by the Secretary. No decision process restricted to comparing claimants' medical evidence to a fixed, finite set of medical criteria can respond adequately to the infinite variety of medical conditions and combinations thereof, the varying impact of such conditions due to the claimant's individual characteristics, and the constant evolution of medical diagnostic techniques.

The Secretary's claim that a functional analysis of child disability claims is not feasible is unconvincing. The fact that a *vocational* analysis is inapplicable to children does not mean that a *functional* analysis cannot be applied to them. An inquiry into the impact of an impairment on the normal daily activities of a child of the claimant's age—speaking, walking, washing, dressing, and feeding oneself, going to school, playing, etc.—is, in our view, no more amorphous or unmanageable than an inquiry into the impact of an adult's impairment on his ability to perform "any other kind of substantial gainful work which exists in the national economy," § 1382c(a)(3)(B).²⁰ Moreover, the Secretary tacitly acknowledges that functional assessment of child claimants is possi-

²⁰The Secretary's own regulations state that this inquiry involves assessment of an adult claimant's ability to "do physical activities such as walking, standing, lifting, carrying, pushing, pulling, reaching, handling," and his ability "to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting." 20 CFR §§ 416.945(b) and (c) (1989). It is difficult to see why such functional assessment would be feasible for adults and not for children.

88-1377—OPINION

18

SULLIVAN *v.* ZEBLEY

ble, in that some of his own listings are defined in terms of functional criteria. See, *e. g.*, 20 CFR pt. 404, subpt. P, App. I (pt. B), §§ 101.03 (listing for “Deficit of musculoskeletal function” defined in terms of difficulty in walking or “[I]nability to perform age-related personal self-care activities involving feeding, dressing, and personal hygiene”); § 111.02(B) (listing for “Major motor seizures” defined in terms of “Significant interference with communication” or “Significant emotional disorder,” or “Where significant adverse effects of medication interfere with major daily activities”); § 112.05(C) (mental retardation listing for claimants with IQ of 60–69 requiring “a physical or other mental impairment imposing additional and significant restriction of function or developmental progression”).²¹ Also, the Secretary’s own test for cessation of disability involves an examination of a child claimant’s ability to “perform age-appropriate activities.” 20 CFR § 416.994(c). Finally, the Secretary’s insistence that child claimants must be assessed from “a medical perspective alone, without individualized consideration of . . . residual functional capacity,” Brief for Petitioner 45, seems to us to make little sense in light of the fact that standard medical diagnostic techniques often include assessment of the functional impact of the disorder.²²

²¹ The Secretary contends that, because some of the child-disability listings include functional criteria, his approach to child disability adequately takes account of functional considerations. Brief for Petitioner 42. This argument is unavailing. The fact that some of the listed impairments are defined in terms of functional criteria is small comfort to child claimants who do not have one of those impairments, and who fail to qualify for benefits for one of the reasons discussed above.

²² See AMA Brief 5 (“The view that proper study or treatment of pediatric illness and injury must include an assessment of the child’s functional capacity to perform age-appropriate activities is well accepted in the medical community The biological severity of an illness is an abstraction, measured only by proxies, the most familiar of which are physiological severity, functional severity and burden of illness”).

88-1377—OPINION

SULLIVAN *vs.* ZEBLEY

19

VI

We conclude that the Secretary's regulations and rulings implementing the child-disability statute simply do not carry out the statutory requirement that SSI benefits shall be provided to children with "any . . . impairment of comparable severity" to an impairment that would make an adult "unable to engage in any substantial gainful activity." § 1382c(a)(3)(A). For that reason, the Secretary's approach to child disability is "manifestly contrary to the statute," *Chevron*, 467 U. S., at 844, and exceeds his statutory authority.

The judgment of the Court of Appeals, vacating in part the District Court's grant of summary judgment in the Secretary's favor as to the claims of the plaintiff class, is affirmed.

It is so ordered.

SUPREME COURT OF THE UNITED STATES

No. 88-1377

LOUIS W. SULLIVAN, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER *v.*
BRIAN ZEBLEY ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE THIRD CIRCUIT

[February 20, 1990]

JUSTICE WHITE, with whom THE CHIEF JUSTICE joins,
dissenting.

Only two Terms ago, when reviewing an aspect of the Secretary's methodology for evaluating disability applications under this Act, we emphasized that "Congress has 'conferred on the Secretary exceptionally broad authority'" in this context, and we stated that the Secretary's regulations were therefore entitled to great deference. *Bowen v. Yuckert*, 482 U. S. 137, 145 (1987), quoting *Heckler v. Campbell*, 461 U. S. 458, 466 (1983). Because the majority has failed to abide by this principle, I respectfully dissent.

As this case involves a challenge to an agency's interpretation of a statute that the agency was entrusted to administer, *Chevron U. S. A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U. S. 837 (1984), provides the framework for our review. We should therefore first ask whether Congress has expressed a clear intent on the question at issue here; if so, we should enforce that intent. If not, as I think is the case, we should defer to the agency's interpretation as long as it is permissible. *Id.*, at 842-845.

Section 1614(a)(3)(A) of the Social Security Act, 42 U. S. C. § 1382c(a)(3)(A) (1982 ed.) provides that a person is disabled if he is unable by reason of any medically determinable physical or mental impairment to engage in any substan-

88-1377-DISSENT

2

SULLIVAN *v.* ZEBLEY

tial gainful employment; subsection (3)(B) further defines "disability" by providing that the impairment or impairments must be severe enough, considering the person's age, education, and work experience to prevent him from engaging in any kind of substantial gainful employment which exists in the national economy. The Secretary has implemented the statute with respect to adults by regulations listing certain impairments that he will, without more, consider disabling because each of them would prevent an adult from engaging in any kind of gainful employment. 20 CFR pt. 404, Appendix 1 to subpart P (1989). If not suffering from one of those impairments or its equivalent, an adult is then given further consideration as required by subsection (3)(B) in order to determine whether in light of his impairment and the specified nonmedical factors he could perform any substantial gainful activities in the national labor market.

At the end of 42 U. S. C. § 1382c(a)(3)(A), with its definition of disability, is a parenthetical provision defining that term in the case of persons under 18: "or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity." There is no reference to nonmedical factors in this definition and no references to specific consequences that an impairment must or should produce. Furthermore, neither "comparable", "severity", nor the two words together are there or elsewhere defined in the Act, and their meaning is anything but clear. The severity of an impairment that disables an adult is measured by its effects on the ability to engage in gainful employment. But that yardstick is not useful with respect to children, whose inability to work is not due to mental or physical impairment, but to the stage of their development and the labor market. Given this task of comparing apples and oranges, it is understandable that the Secretary implemented the statute with respect to children in a somewhat different manner than he did for adults, and surely

88-1377-DISSENT

SULLIVAN *vs.* ZEBLEY

3

there is no direction in the statute to employ the same methodology for both groups.

Under the regulations applying to children, a person under 18 will be considered disabled if suffering from a Part A impairment listed for adults or its equivalent, as long as the disease's processes have a similar effect on adults and younger persons. Because vocational considerations are largely beside the point in dealing with children—a fact that the Secretary submits Congress recognized in referring only to medical considerations in subsection (3)(A)'s definition of what would disable a child—the regulations do not provide for further consideration of the child in light of such factors. Instead, a child not suffering from a Part A impairment is evaluated under an additional listing of impairments in Part B of Appendix 1 to subpart P, any of which, or its equivalent, will be deemed sufficient to disable a child. The preamble to Part B, published in 1977, 42 Fed. Reg. 14705, stated that in identifying medical criteria that would establish disability for a child, the Secretary had placed primary emphasis on the effects of physical and mental impairments in children, and the restrictions on growth, learning, and development imposed on the child by the impairments. The impairments that were determined to affect the child's development to the same extent that the adult criteria have on an adult's ability to engage in substantial gainful activity were deemed to be of "comparable severity" to the disabling adult impairments.

I do not find this approach to be an impermissible implementation of the rather ambiguous congressional directives with respect to children. Surely it cannot be said that the regulations, insofar as they use the Part A and Part B listings, singly or in combination, to identify disability in children, are inconsistent with the statute and void on their face. And as I understand it, no one claims that they are. What is submitted is, first, that the listings do not identify all of the specific medical impairments that should be considered dis-

88-1377-DISSENT

4

SULLIVAN v. ZEBLEY

abling, and second, that each child not deemed disabled under Parts A and B must be evaluated in terms of both his or her medical impairments and nonmedical factors, as are adults.

These alleged deficiencies are said to be sufficient to invalidate the regulations on their face. But surely these claims, if true, only would demonstrate that the regulations do not go far enough. Furthermore, the claims purport to be supported by descriptions of various unlisted impairments and anecdotal evidence, none of which, it seems to me, has been adjudged by a court to be sufficient to demonstrate that the Part B impairments, or their equivalents, fail to identify impairments that will have comparably severe effects on a child's development as the disabling impairments for an adult will have on an adult's ability to engage in substantial gainful employment. If there are medically determinable diseases or impairments that should be considered disabling because of comparable severity to those affecting adults, the children suffering from them should claim disability, make their case before the Secretary, and take the case to court if their claims are rejected.¹ As for the more general attack on the regulation—that they do not provide for individualized evaluation based on nonmedical factors—the Secretary contends

¹The majority suggests that the agency has conceded that its listing approach is not intended to satisfy the statutory standard of "comparable severity" because the Secretary only designed the lists to compensate claimants who suffer from disabilities that prevent any gainful activity, rather than claimants who suffer from disabilities that prevent any substantial gainful activity. It is difficult, however, particularly in light of the agency's interpretation of its own regulations, to extract from them an admission on the agency's part that it has failed to fulfill its statutory responsibilities. The regulations specifically state both that "[t]he law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment . . ." and that "[i]f you are under age 18, we will consider you disabled if you are suffering from any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult (a person over 18) disabled." 20 CFR §§ 416.905, 416.906 (1989).

88-1377-DISSENT

SULLIVAN *v.* ZEBLEY

5

that it is a reasonable construction of Section 3-A to confine disabling criteria to medical factors where children are concerned. In any event, rather than declaring the regulations wholly or partly void on their face, the Court would be better advised to insist on children making out their claims in individual cases; only then can a court confidently say that the medically identifiable impairment, though neither a listed impairment nor its equivalent, is nevertheless of "comparable severity" and hence disabling when considered with nonmedical factors.

I thus largely agree with District Judge Fullam's view of this case:

"Plaintiff's argument may well be valid, in many cases; but errors in applying the regulations in some cases do not demonstrate invalidity of the regulations themselves. Part B of the Secretary's listings of impairments, 20 CFR § 416.925, is not facially invalid or incomplete, seems to provide the necessary flexibility, and, in my view, permits the award of benefits in conformity with the intent of Congress. If these criteria are being misapplied or misinterpreted, the remedy lies in the appeal process in individual cases, not in a class-action decree." *Zebley v. Heckler*, 642 F. Supp. 220, 222 (E.D. Pa. 1986).

The difference, furthermore, between the Secretary's regulatory approach toward adults and his approach toward children accords with the different purposes underlying the disability programs for the two groups. Congress provided disability benefits for adults in order to ensure "the basic means of replacing earnings that have been lost as a result of . . . disability" for those who "are not able to support themselves through work" H. R. Rep. No. 92-231, pp. 146-147 (1971). For this reason, insofar as adults are concerned, the Act defines disabilities in terms of the effect that the disabilities have on the claimant's ability to function in the workplace. In light of this purpose, it is appropriate for the

88-1377-DISSENT

6

SULLIVAN *vs.* ZEBLEY

Secretary to evaluate adults not only in terms of the severity of their impairment, but also in terms of their residual functional capacity to perform work.

By contrast, Congress had a different set of considerations in mind when it provided for children's benefits. Recognizing that disabled children from low-income households are "among the most disadvantaged of all Americans," Congress provided special disability benefits for these persons "because their needs are often greater than those of nondisabled children." H. R. Rep. No. 92-231, *supra*, at 147-148. In other words, Congress' aim in providing benefits to these individuals was not to replace lost income, but rather to provide for their special health care expenses, such as the home health care costs arising out of the child's medical disability. It is consistent with this quite distinct purpose to focus consideration on the severity of the child's impairment from a medical perspective alone, without individualized consideration of vocational or similar factors or the claimant's residual functional capacity. The nature and severity of a child's impairment, rather than the child's ability to contribute to his family's income, will necessarily determine the child's entitlement to benefits.²

² Congress' acquiescence in the Secretary's regulatory technique for assessing child disability applications supports the position that the Secretary's approach is reasonable. In 1976, Congress directed the Secretary to publish his criteria for evaluating disability payments for children. Unemployment Compensation Amendments of 1976, § 501(b), 90 Stat. 2685. Despite the majority's contention to the contrary, the history of this legislation indicates that Congress understood and, at least implicitly, condoned the Secretary's methodology for evaluating child disability claims. The Senate Report states:

"The regulations which have been issued with regard to disability for children state that if a child's impairments are not those listed, eligibility may still be met if the impairments 'singly or in combination . . . are determined by the Social Security Administration, with appropriate consideration of the particular effect of the disease processes in childhood, to be medically the equivalent of a listed impairment.'" S. Rep. No. 94-1265, p. 24 (1976).

BOB PACKWOOD, OREGON, CHAIRMAN

BOB COLE, KANSAS
WILLIAM V. ROY, JR., DELAWARE
JOHN H. CHAFFE, RHODE ISLAND
CHARLES E. GRAZLEY, IOWA
OWEN G. MATH, UTAH
ALAN K. SIMPSON, WYOMING
LARRY PRESSLER, SOUTH CAROLINA
ALFONSO M. GAMATO, NEW YORK
FRANK M. MURKOWSKI, ALASKA
DON J. JOHNS, OKLAHOMA

DANIEL T. DICK, MICHIGAN, NEW YORK
MAX BAUCUS, MONTANA
BIL BRADLEY, NEW JERSEY
DAVID PRYOR, ARIZONA
JOHN G. ROCKEFELLER IV, WEST VIRGINIA
JOHN BREAUX, LOUISIANA
ICENT CONRAD, NORTH CAROLINA
BOB GRAHAM, FLORIDA
CAROL MOSLEY-BRAUN, ILLINOIS

LINDY L. PAUL, STAFF DIRECTOR AND CHIEF COUNSEL
LAWRENCE GOSWELL, JR., MINORITY STAFF DIRECTOR

United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

April 20, 1995

Appendix 5

The Honorable Jim Slattery
Chair
National Commission on Childhood Disability
801 Pennsylvania Avenue, N.W.
Suite 625
Washington, DC 20004

Dear Congressman Slattery:

As you know, the House has already passed a welfare bill which includes significant reforms to the way children are treated under the supplemental security income program. Because the House welfare bill was referred to the Senate Finance Committee, the Committee is now considering how the program could be reformed to better suit the needs of truly disabled children.

I am pleased to hear that the commission is moving forward and has begun the process of formulating some recommendations to send to Congress. While I understand the commission has sped up the timeline on reporting its recommendations, I can't emphasize enough the importance of sending these recommendations to Congress as quickly as possible so they can be part of the discussion.

If you have any questions, or would like to submit any preliminary findings or recommendations, please don't hesitate to call Kathy Tobin (224-4515) of my staff.

Thank you,

Bob Packwood

BOB PACKWOOD
Chairman

Preliminary Recommendations
of the
National Commission on Childhood Disability

Appendix 5

Summary

1. Purpose of SSI Childhood Disability Program - The Commission sees the purpose of the SSI childhood disability program as assisting low-income families (and other individuals and organizations who care for children with disabilities) in (a) providing basic necessities to maintain a child with a disability at home or in another appropriate setting; (b) covering the additional costs of caring for and raising a child with a disability; (c) enhancing the child's opportunity to develop; and (d) offsetting lost family income because a parent remains unemployed or underemployed to care for the child.
2. Administering Agency - The Commission recommends that the SSI childhood disability program be transferred from the Social Security Administration to the Department of Health and Human Services.
3. Recommendations to Strengthen the Pro-Family Character of the SSI Program
 - a. Eliminate six-month limit on spending retroactive lump-sum benefits and require that such benefits be used to cover the cost of needs related to the child's disability and/or for increasing his or her independence
 - b. Continue Medicaid eligibility for children who leave the SSI rolls due to medical improvement but who need treatment to maintain their improved condition
 - c. Disregard minor siblings' earnings in determining a disabled child's eligibility
 - d. Expand SSI eligibility for disabled children of military personnel to include those who apply while overseas
 - e. Require HHS to initiate partnerships and linkages with private groups aimed at improving service delivery to children and families (TO BE DETERMINED after the Commission receives Arango task force recommendation)

Appendix 5

4. Recommendations to Strengthen the Childhood Definition of Disability

- a. Establish a new childhood definition of disability which builds on the "functional equals" step in SSA's current sequential evaluation process, thus retaining the concept of functional assessment but requiring listing level severity for functional allowances (new definition would require expansion of domains in SSA's current listings to capture more impairments), or

Prohibit IFA benefit allowances based on moderate limitations in three functional domains but preserve the option for IFA allowances based on one marked and one moderate limitation.

- b. Eliminate double counting of maladaptive behavior by deleting it from the personal domain in the SSI childhood mental impairments listings
- c. Recommend restructuring of existing domains in SSA's childhood listings to eliminate overlap

5. Place a Limit on Family Benefits

SPECIFIC LIMIT TO BE DETERMINED

6. Require Continuing Disability Reviews (CDRs)

- a. Require CDRs at least every two years for children who have likelihood of sufficient improvement to be ineligible for cash benefits; authorize HHS to conduct CDRs more frequently for some children if appropriate
- b. Establish a revolving fund to cover the cost of CDRs

7. Requirement for Treatment - Participation in treatment would be required as a condition of eligibility for SSI childhood disability benefits in those cases where it is

- * readily available in the child's community,
- * affordable to parents, and
- * likely to result in improvement in the child's condition.

8. Recommendations to Increase Accountability

Increase accountability of families and other representative payees; SPECIFIC RECOMMENDATION TO BE DETERMINED

MEMORANDUM

June 8, 1995

Appendix 6-A

FROM: Karen W. Sherif
Office of the Actuary

TAC

SUBJECT: Estimated Impact on Federal SSI Payments and Numbers of Beneficiaries Due to Recommendations Being Considered by the National Commission on Childhood Disability--INFORMATION

The following paragraphs describe miscellaneous proposals related to SSI childhood disability benefits prepared by the National Commission on Childhood Disability. These descriptions and our understanding of the principles underlying the various recommendations are based on sections of the Commission's draft report provided to us by the staff of the Commission. The numbering in the paragraphs below is based on the sections of that draft report. Estimates of the reductions in SSI Federal payments and numbers of SSI beneficiaries in payment status are presented in tables following these descriptions.

1. Purpose of SSI Childhood Disability Program (Informational statement)
2. Strengthen the Pro-Family Character of the SSI Program

- a. *Eliminate the 6-month limit on excluding retroactive lump-sum benefits from countable resources and require that such benefits be used to cover the cost of needs related to the child's disability and/or for increasing his or her independence.*

This recommendation would eliminate the 6-month limit on excluding retroactive lump-sum benefits from countable resources and permit recipients of such benefits to retain these benefits without a time limit. In the past, we have not observed a significant program impact when time-limits have changed. We continue to believe that nearly all recipients find a way to spend-down within the prescribed time limit so as not to lose SSI eligibility for even 1 month. Consequently, eliminating the time limit would only increase SSI program costs in the rare event that an individual does not completely spend-down within the current 6-month limit and loses a month(s) of benefits while still spending down. Therefore, we estimate that the additional SSI program cost due to this proposal would be negligible.

- b. *Continue Medicaid eligibility for children who become ineligible for SSI cash benefits because of medical improvement, but who require continued access to Medicaid to maintain that improvement.*

According to staff in HCFA's Office of the Actuary, the vast majority of children leaving the SSI program continue to be Medicaid eligible either because (1) they qualify for AFDC (thus giving them categorical eligibility for Medicaid) or (2) they qualify as medically needy (since their financial situation places them below an appropriate poverty level). HCFA's actuaries will provide the estimated Medicaid impact of this proposal. There is no SSI program cost.

- c. *Increase earned income exclusion for minor siblings' earnings in determining a disabled child's eligibility.*

Data on ineligible siblings of SSI eligible children is extremely limited, not to mention the income of such siblings. For purposes of this request, we assumed that the only cases affected are those that (1) currently deem income to the eligible child, (2) have at least one ineligible minor child with income living in the same household, and (3) report that income even though it causes the SSI benefit to be reduced. Based upon SSI deeming and household data supplemented by general population employment information, we estimate that this proposal would have a negligible impact on SSI program costs.

- d. *Expand SSI eligibility for dependents of military personnel to include those who apply while overseas.*

This recommendation would allow children of military personnel who are born overseas or those who become disabled while living overseas to be eligible for participation in the SSI program. Additional SSI program cost would occur for all months of eligibility subsequent to returning to the United States. Once in the United States, the child would be eligible for participation under current law. We estimate that this proposal would have a negligible impact on SSI program costs.

- e. *Require SSA to initiate partnerships and linkages with private groups aimed at improving service delivery to children and families.*

This recommendation is aimed at improved service delivery and no SSI program cost/savings is anticipated.

3. Recommendations to Strengthen the Childhood Definition of Disability—The Commission appears evenly divided on the question of how to revise the definition of disability for children. The following paragraphs describe two alternatives that will be included in the Commission's final report.

- a. *OPTION 1—Establish a new childhood definition of disability that builds on the "functional equals" step in SSA's current sequential evaluation process, retaining the concept of functional assessment, but requiring two marked limitations, eliminating allowances based in part or in whole on moderate limitations.*
OPTION 2—Preserve the SSA individual functional assessment guidelines allowing one marked and one moderate limitation, eliminating allowances based on three moderates.

Based on conversations with the Commission's staff, option 1 is intended to mirror the revised definition proposed by Senator Moynihan in the Senate Finance Committee, and be applicable both retrospectively and prospectively. In the absence of detailed specifications for the implementation of the revised definition, we have assumed that the new standard would apply to new awards beginning 6 months after enactment. Terminations due to reviews of disabled children on the rolls as of enactment were assumed to begin roughly 6 months after enactment, and continue over the following 2 years. Such reviews would be conducted without regard to the requirement for substantiating medical improvement. We estimate that about 20 percent of the SSI current payment caseload and new awards will be affected by the option 1 definition

in conjunction with the maladaptive behavior change described in 3.d.

Similarly, the Commission's staff indicated that the revised definition under option 2 is intended to be similar to a change introduced by Senator Conrad, but with the additional restrictions introduced by certain changes in the evaluation of maladaptive behavior (see 3.d below). We also understand that as in option 1, the intent is to review all current payment cases likely to be affected by these changes, and to terminate cases without regard to the medical improvement requirement. This retrospective application of the new definition was not part of the Conrad bill. As in option 1, we have assumed that the new definition would be effective for new awards beginning 6 months after enactment, and that terminations of disabled children on the rolls as of enactment would begin roughly 6 months after enactment and continue over the following 9 months. We estimate that about 8 percent of the SSI current payment caseload and new awards will be affected by the option 2 definition in conjunction with the maladaptive behavior change in 3.d.

b. *Provide Medicaid for children with moderate limitations.*

No SSI program cost.

c. *SSA Judges would classify an impairment as marked if there is evidence to support either marked or moderate.*

No SSI program cost.

d. *Eliminate double counting of maladaptive behavior by deleting it from the personal domain in the childhood mental impairment listings.*

The impact of this provision is included in both options 1 and 2 under 3.a above.

4. **Establish a Sliding Scale for Family Members**

The Commission recommends the establishment of a scale that reduces benefits in situations where more than one child in the same family is eligible for SSI cash benefits. The scale would be sliding such that the maximum benefit payable to a family with two eligible minor children would be \$744, rather than \$916 as under present law, and to a family with three eligible minor children would be \$988 instead of \$1,374. We assumed that this sliding scale would apply to new awards beginning October 1, 1995. We further assumed that the current caseload would also be subject to this sliding scale, but we assumed up to 12 months would be needed to determine to which households this new scale would apply, and to reduce the benefits to those affected. We estimate that about 35,000 households would receive a reduction in SSI Federal payments as a result of this recommendation in FY 1996. Since the vast majority of affected households are composed entirely of a single nuclear family, it is unlikely that many would change their household composition as a direct result of the reduction in benefits.

5. **Require Continuing Disability Reviews (CDRs)**

a. *Require CDRs at least every 2 years for children who have likelihood of sufficient improvement to be ineligible for cash benefits; authorize SSA to conduct CDRs more*

frequently for some children if appropriate.

This recommendation requires CDRs for the cases with medical improvement expected. Although SSA is in the process of conducting CDRs for an initial batch of 5,000 cases of SSI disabled children, there continues to be very little data on CDRs for children and how they differ from adult CDRs. Until the results of this first round of childhood CDRs are available, we do not have adequate data to develop reliable cessation rates for SSI children. For rough planning purposes in evaluating this proposal, we have assumed that for the near term SSI cessations would be somewhat lower than cessations experienced for CDRs conducted under the DI program.

b. *Establish a revolving fund to cover the cost of CDRs.*

No SSI program cost.

6. Requirement for Treatment

No SSI program cost.

7. Provide Categorical Eligibility for Medicaid for All SSI Children

No SSI program cost.

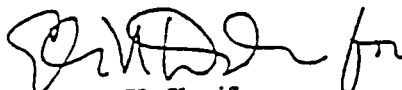
8. Revise Reporting Requirements for Children's Representative Payees

No SSI program cost.

9. AFDC Recommendation

No SSI program cost.

The attached tables present the estimated impact of the proposals described above on Federal SSI payments and average numbers of beneficiaries in payment status under each of the two options for changing the definition of childhood disability. In each set of estimates, an enactment date of October 1, 1995, was assumed and all estimates are based upon the assumptions underlying the President's Fiscal Year 1996 Budget.


Karen W. Sherif

Attachment

Table 1.—Estimated reductions in Federal SSI payments under two alternatives for revising the standards for the payment of benefits to disabled children, fiscal years 1996-2000
(In millions)

Fiscal year	Option 1			Option 2		
	Change in definition	All other proposals ^{1/}	Total	Change in definition	All other proposals ^{1/}	Total
1996	\$150	\$50	\$200	\$110	\$ 50	\$160
1997	760	90	850	480	100	580
1998	1,290	100	1,390	550	110	660
1999	1,510	110	1,620	600	130	730
2000	<u>1,650</u>	<u>130</u>	<u>1,780</u>	<u>660</u>	<u>150</u>	<u>810</u>
Total, 1996-2000	5,360	480	5,840	2,400	540	2,940

^{1/} Reflects impact from interaction between the remaining proposals and the modifications to the definition of disability.

Table 2.—Estimated reductions in the average number of Federal SSI recipients under two alternatives for revising the standards for the payment of benefits to disabled children, fiscal years 1996-2000
(In thousands)

Fiscal year	Option 1			Option 2		
	Change in definition	All other proposals ^{1/}	Total	Change in definition	All other proposals ^{1/}	Total
1996	30	(<u>2</u>)	30	20	(<u>2</u>)	20
1997	130	(<u>2</u>)	130	80	(<u>2</u>)	80
1998	210	(<u>2</u>)	210	90	(<u>2</u>)	90
1999	240	(<u>2</u>)	240	100	(<u>2</u>)	100
2000	250	10	260	100	10	110

^{1/} Reflects impact from interaction between the remaining proposals and the modifications to the definition of disability.

^{2/} Less than 10 thousand cases.

Social Security Administration
Office of the Actuary
June 8, 1995

June 21, 1995

MEMORANDUM

FROM: Isidor Strauss
Office of the Actuary

SUBJECT: Medicaid savings due to changed definitions of childhood disabilities.

This memo will address the Medicaid effect of the changes in definition of childhood disability as proposed by the National Commission on Childhood Disability (proposals 3a and 3d).

It should be noted that one of the recommendations of the Commission was to preserve Medicaid eligibility for these children. If that recommendation is accepted, then there would obviously be no Medicaid savings from the change in definition. This memo, therefore, looks at only the effect of the change in definition in combination with the elimination of maladaptive behavior from the personal domain, in isolation from all other recommendations.

The Commission itself was split as to which way to go about changing the childhood disability definitions and presented two options. Both of these options have been estimated.

Previously used per capita costs were modified on the assumption that children who fall into this category are by definition not as disabled and that their medical costs would be correspondingly lower.

After the savings were calculated for eliminating the Medicaid benefits for these children, offsets to the savings were calculated on the assumption that most of them would find their way back onto the Medicaid program through some other eligibility category, either as a poverty level child or as a member of an AFDC family. This decreases the expected savings considerably, as can be seen from the accompanying table.

Appendix 6-B

medicaid savings if medicaid not preserved for changed definitions
of disability and elimination of maladaptive behavior

	FY96	FY97	FY98	FY99	FY00
Option I caseloads (000s)	30	130	210	240	250
modified per capita	4274	4456	4674	4898	5148
Savings before offsets (\$ Millions)	128	579	982	1176	1287
Federal share	73	330	559	670	734

Option II caseloads (000s)	20	80	90	100	100
modified per capita	4274	4456	4674	4898	5148
Savings before offsets (\$ Millions)	85	356	421	490	515
Federal share	49	203	240	279	293

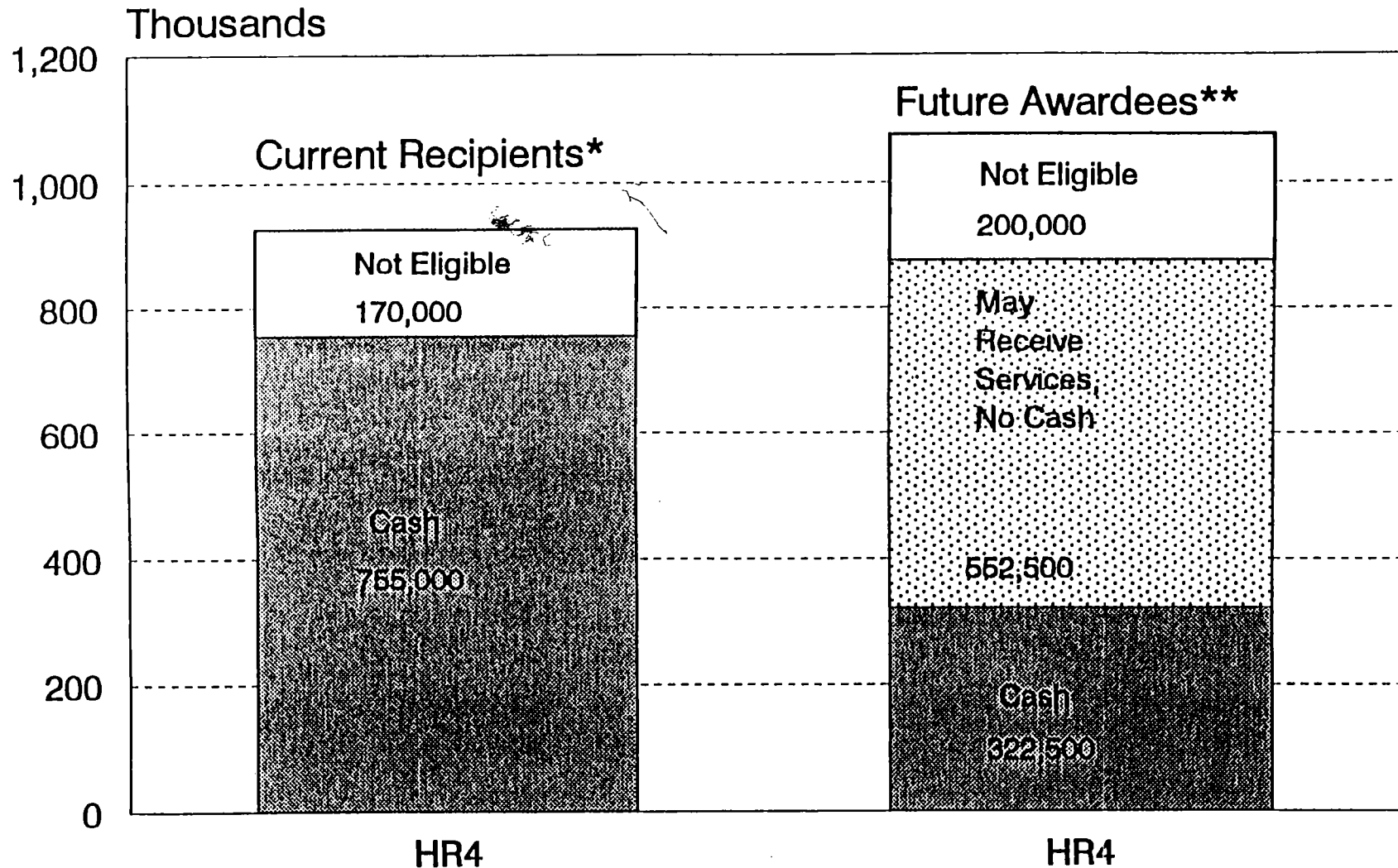
Offsets to these savings
0.65 poverty level
0.5 get on AFDC

Net savings (Fed share, rounded to nearest \$5 Million)

Option I	15	60	100	115	130
Option II	10	35	40	50	50

Office of the Actuary
June 21, 1995

Proposal to Modify the Definition of SSI Childhood Disability Eligibility Criteria in HR4



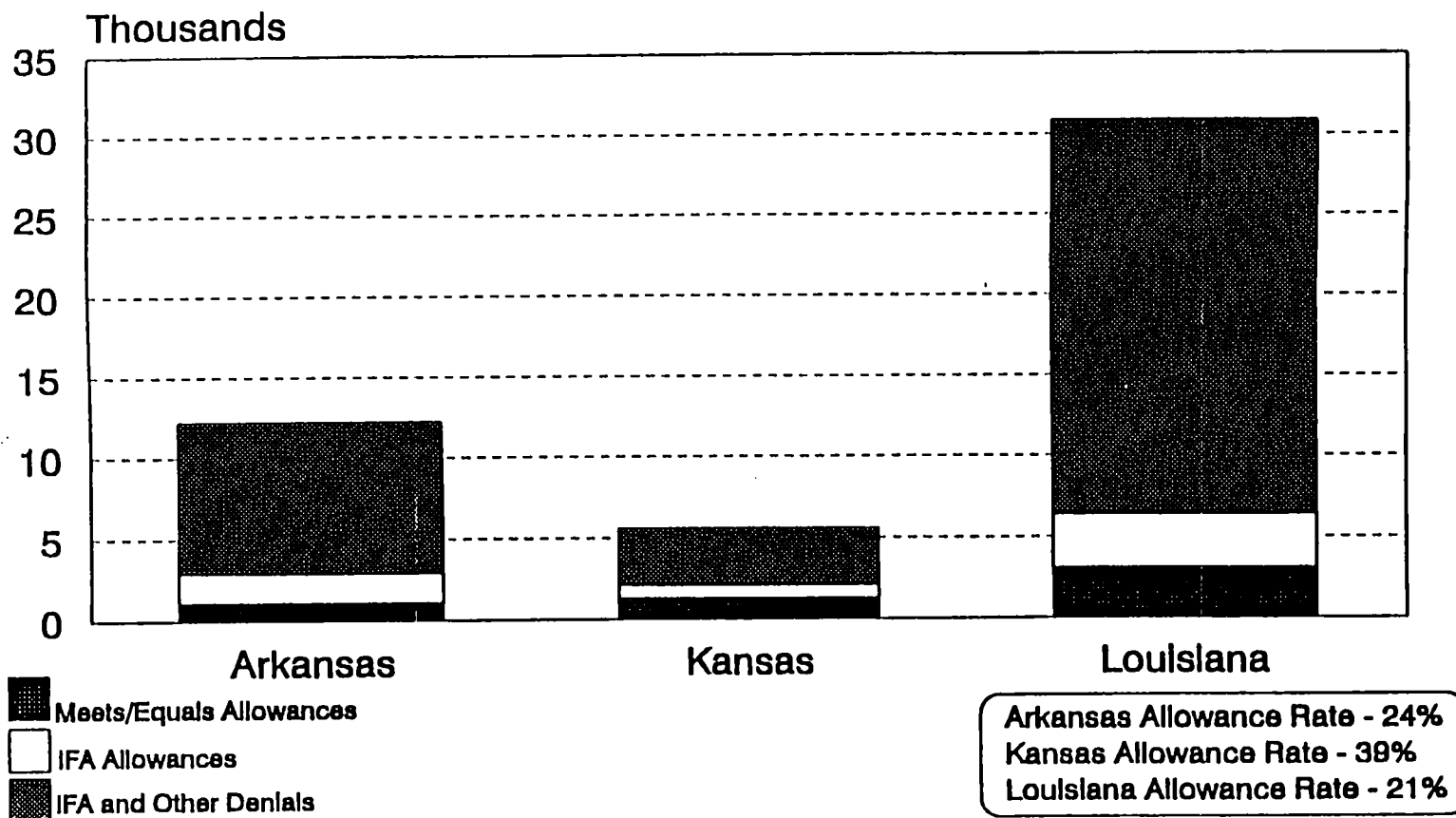
*Estimated recipients as of October 1995.

**Estimated new awardees cumulative from October 1995-September 2000.

Source: Congressional Budget Office Estimates

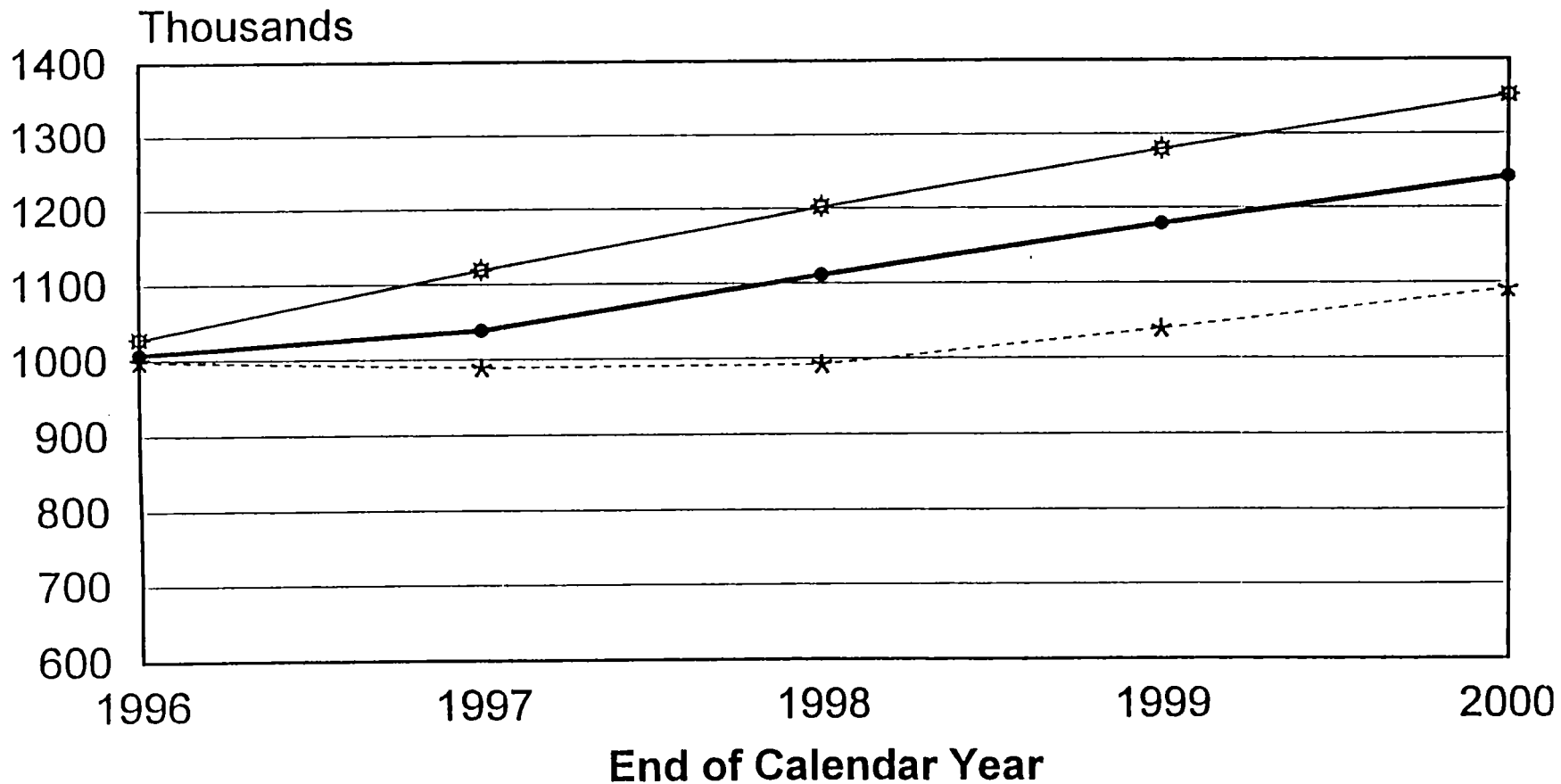
Title XVI Disabled Children
Initial Level Determinations
Calendar Year 1994

A Comparison of Arkansas, Kansas, & Louisiana



Prepared by: Social Security Administration

Estimated SSI Program Growth Under Two Alternatives for Revising Eligibility Standards, Compared to the SSA Caseload Baseline



* 2 Marked Limitations Standard ● 1 Marked-1 Moderate Limitation Standard
* SSA Baseline Growth

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
NATION	425,808	62.4%	70,149	8.6%	58,508	7.2%	251,108	30.9%	6,838	0.8%	812,409	100.0%
ALABAMA	12,641	54.4%	1,693	7.3%	1,244	5.4%	7,631	32.8%	28	0.1%	23,237	100.0%
ALASKA	570	59.9%	90	9.5%	99	10.4%	188	19.6%	8	0.8%	951	100.0%
ARIZONA	5,965	65.6%	427	4.7%	531	5.8%	2,058	22.6%	108	1.2%	9,087	100.0%
ARKANSAS	4,924	29.9%	497	3.0%	2,238	13.6%	8,723	53.0%	74	0.4%	18,454	100.0%
CALIFORNIA	38,769	85.3%	8,860	11.6%	3,557	8.0%	9,534	18.1%	819	1.0%	59,339	100.0%
COLORADO	3,583	40.8%	3,247	36.9%	733	8.3%	1,197	13.6%	31	0.4%	8,791	100.0%
CONNECTICUT	2,471	58.9%	390	9.0%	252	5.8%	1,177	27.1%	54	1.2%	4,344	100.0%
DELAWARE	1,128	81.1%	107	5.8%	269	14.6%	326	17.7%	14	0.8%	1,842	100.0%
DISTRICT OF COLUMBIA	1,338	55.6%	148	8.1%	427	17.8%	488	20.3%	8	0.3%	2,405	100.0%
FLORIDA	30,998	67.2%	2,035	4.4%	4,059	8.8%	8,827	19.1%	188	0.4%	46,107	100.0%
GEORGIA	13,639	62.8%	1,708	7.9%	2,323	10.7%	3,952	18.2%	55	0.3%	21,677	100.0%
HAWAII	845	79.9%	87	8.3%	20	2.5%	73	9.0%	2	0.2%	807	100.0%
IDAHO	1,687	43.2%	331	8.5%	292	7.5%	1,538	39.4%	58	1.4%	3,904	100.0%
ILLINOIS	24,594	53.0%	3,040	6.5%	2,945	8.3%	15,503	33.4%	333	0.7%	46,415	100.0%
INDIANA	8,304	47.8%	1,765	10.2%	1,145	6.6%	6,013	34.6%	135	0.8%	17,382	100.0%
IOWA	4,183	58.6%	379	5.3%	584	8.2%	1,804	26.7%	87	1.2%	7,137	100.0%
KANSAS	3,836	47.4%	904	11.2%	702	8.7%	2,587	31.9%	71	0.9%	8,100	100.0%
KENTUCKY	7,719	42.1%	744	4.1%	1,578	8.6%	8,254	45.0%	63	0.3%	18,358	100.0%
LOUISIANA	15,436	42.4%	1,389	3.8%	1,881	5.2%	17,507	48.1%	159	0.4%	36,372	100.0%
MAINE	1,385	68.4%	294	14.1%	134	6.4%	270	12.8%	4	0.2%	2,087	100.0%
MARYLAND	5,881	57.0%	682	8.4%	926	9.0%	2,825	27.4%	19	0.2%	10,313	100.0%
MASSACHUSETTS	7,634	53.3%	1,738	12.1%	1,088	7.5%	3,551	24.8%	332	2.3%	14,321	100.0%
MICHIGAN	18,019	49.6%	2,434	6.7%	2,454	6.7%	13,074	38.0%	380	1.0%	36,361	100.0%
MINNESOTA	4,797	48.2%	994	10.0%	1,118	11.2%	2,948	29.8%	96	1.0%	9,951	100.0%
MISSISSIPPI	7,544	35.3%	2,422	11.3%	1,998	9.3%	9,302	43.5%	130	0.6%	21,394	100.0%
MISSOURI	8,062	48.9%	1,659	9.6%	1,159	6.7%	8,055	35.2%	288	1.8%	17,203	100.0%
MONTANA	1,090	81.1%	174	9.8%	129	7.2%	384	21.5%	8	0.3%	1,783	100.0%
NEBRASKA	1,790	53.1%	272	8.1%	381	11.3%	894	28.5%	36	1.1%	3,373	100.0%
NEVADA	1,482	60.3%	323	13.3%	328	13.5%	298	12.3%	14	0.6%	2,423	100.0%
NEW HAMPSHIRE	1,078	72.3%	208	14.0%	75	5.0%	128	8.5%	4	0.3%	1,491	100.0%
NEW JERSEY	8,882	47.3%	3,387	17.9%	1,270	8.8%	5,051	26.9%	208	1.1%	18,776	100.0%
NEW MEXICO	2,451	46.2%	893	18.8%	584	11.2%	1,345	25.4%	20	0.4%	5,303	100.0%
NEW YORK	31,500	44.9%	7,215	10.3%	3,862	5.5%	28,415	37.7%	1,123	1.8%	70,115	100.0%
NORTH CAROLINA	9,740	41.6%	1,134	4.8%	2,018	8.6%	10,425	44.5%	88	0.4%	23,403	100.0%
NORTH DAKOTA	658	64.6%	102	10.0%	68	6.7%	173	17.0%	17	1.7%	1,018	100.0%
OHIO	27,244	60.2%	5,238	11.6%	1,887	3.7%	10,893	24.1%	167	0.4%	45,229	100.0%
OKLAHOMA	8,432	70.0%	700	7.6%	382	3.9%	1,881	18.3%	17	0.2%	9,182	100.0%
OREGON	3,997	88.5%	318	5.4%	520	8.9%	958	18.4%	48	0.8%	5,837	100.0%
PENNSYLVANIA	17,077	46.9%	3,779	10.4%	2,728	7.5%	12,495	34.3%	310	0.8%	36,387	100.0%
RHODE ISLAND	1,178	58.8%	100	5.0%	133	8.6%	582	29.0%	15	0.7%	2,008	100.0%

Appendix 7-D

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

Appendix 7-D

STATE	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC.*	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
SOUTH CAROLINA	8,428	59.6%	888	6.3%	1,127	8.0%	3,653	25.8%	49	0.3%	14,145	100.0%
SOUTH DAKOTA	1,139	52.6%	77	3.6%	278	12.8%	631	29.1%	41	1.9%	2,168	100.0%
TENNESSEE	11,163	82.8%	1,172	6.6%	1,004	6.6%	4,356	24.5%	90	0.6%	17,785	100.0%
TEXAS	24,012	55.9%	2,162	5.0%	2,999	7.0%	13,331	31.0%	475	1.1%	42,969	100.0%
UTAH	2,574	61.6%	284	6.8%	225	5.4%	1,070	25.6%	27	0.8%	4,180	100.0%
VERMONT	468	36.9%	227	17.9%	93	7.3%	87	6.9%	394	31.0%	1,269	100.0%
VIRGINIA	8,898	48.0%	871	4.7%	1,148	6.2%	7,587	40.8%	71	0.4%	18,551	100.0%
WASHINGTON	5,928	54.7%	759	7.0%	1,111	10.3%	2,980	27.3%	78	0.7%	10,834	100.0%
WEST VIRGINIA	4,103	58.5%	341	4.7%	482	6.6%	2,291	31.5%	51	0.7%	7,268	100.0%
WISCONSIN	7,640	37.4%	3,310	16.2%	2,050	10.0%	7,370	36.0%	78	0.4%	20,448	100.0%
WYOMING	417	39.2%	113	10.8%	69	6.5%	431	40.5%	35	3.3%	1,065	100.0%
OTHER**	717	68.6%	112	10.4%	41	3.8%	144	13.4%	62	5.8%	1,076	100.0%

SOURCE: SSA-831 FILE - YEARS 1991 - 1994
PREPARED BY: SOCIAL SECURITY ADMINISTRATION
DATE PREPARED: 2/85

NOTES:

* INCLUDES ALLOWANCES BASED ON MEDICAL/VOCATIONAL CRITERIA (E.G., DISABLED CHILDREN AGE 18 AND OVER), AS WELL AS ALLOWANCES WHERE NO BASIS VALID CODE WAS RECORDED.

** INCLUDES OFFICE OF INTERNATIONAL OPERATIONS CASES, FEDERAL DDS CASES, AND NORTHERN MARIANAS ISLANDS CASES AS WELL AS CASES WITH INVALID DDS CODES.

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
NATION	MENTAL RETARDATION	190,998	81.2%	12,783	4.1%	3,805	1.2%	101,689	32.6%	2,634	0.8%	311,889	100.0%
	OTHER MENTAL	94,303	40.6%	12,655	5.4%	8,091	2.6%	118,538	50.2%	2,737	1.2%	232,224	100.0%
	PHYSICAL	140,507	52.4%	44,811	18.7%	48,610	18.1%	32,901	12.3%	1,487	0.5%	268,298	100.0%
	TOTAL ALL CATEGORIES	425,808	52.4%	70,149	8.6%	58,508	7.2%	251,108	30.9%	6,838	0.8%	812,409	100.0%
ALABAMA	MENTAL RETARDATION	7,143	60.5%	278	2.4%	148	1.2%	4,232	35.8%	13	0.1%	11,812	100.0%
	OTHER MENTAL	2,058	44.3%	101	2.2%	190	4.1%	2,291	49.3%	5	0.1%	4,643	100.0%
	PHYSICAL	3,442	50.8%	1,314	19.4%	908	13.4%	1,108	18.3%	10	0.1%	6,782	100.0%
	TOTAL ALL CATEGORIES	12,641	54.4%	1,693	7.3%	1,244	5.4%	7,631	32.8%	28	0.1%	23,237	100.0%
ALASKA	MENTAL RETARDATION	170	85.9%	9	4.5%	1	0.5%	18	8.1%	2	1.0%	198	100.0%
	OTHER MENTAL	159	45.8%	33	9.5%	20	5.8%	131	37.8%	4	1.2%	347	100.0%
	PHYSICAL	241	59.4%	48	11.8%	78	19.2%	39	9.6%	0	0.0%	408	100.0%
	TOTAL ALL CATEGORIES	570	59.9%	90	9.5%	99	10.4%	188	19.6%	6	0.6%	951	100.0%
ARIZONA	MENTAL RETARDATION	2,270	77.6%	35	1.2%	28	0.9%	557	19.0%	38	1.3%	2,928	100.0%
	OTHER MENTAL	1,359	55.4%	18	0.7%	39	1.6%	1,004	40.9%	35	1.4%	2,455	100.0%
	PHYSICAL	2,338	63.0%	374	10.1%	468	12.6%	495	13.4%	35	0.9%	3,708	100.0%
	TOTAL ALL CATEGORIES	5,965	65.6%	427	4.7%	531	5.8%	2,056	22.6%	108	1.2%	9,087	100.0%
ARKANSAS	MENTAL RETARDATION	2,817	34.6%	24	0.3%	39	0.5%	4,864	64.2%	28	0.4%	7,572	100.0%
	OTHER MENTAL	504	16.8%	38	1.2%	89	3.0%	2,355	78.6%	12	0.4%	2,998	100.0%
	PHYSICAL	1,803	30.6%	437	7.4%	2,108	35.8%	1,504	25.6%	34	0.6%	5,888	100.0%
	TOTAL ALL CATEGORIES	4,924	29.8%	497	3.0%	2,238	13.6%	8,723	53.0%	74	0.4%	16,454	100.0%
CALIFORNIA	MENTAL RETARDATION	12,385	72.8%	1,337	7.8%	351	2.1%	2,818	16.5%	172	1.0%	17,043	100.0%
	OTHER MENTAL	9,357	82.2%	1,032	8.9%	840	4.3%	3,795	25.2%	217	1.4%	15,041	100.0%
	PHYSICAL	17,047	62.5%	4,491	18.5%	2,588	9.4%	2,921	10.7%	230	0.8%	27,255	100.0%
	TOTAL ALL CATEGORIES	38,789	65.3%	6,860	11.6%	3,557	6.0%	9,534	18.1%	619	1.0%	59,339	100.0%
COLORADO	MENTAL RETARDATION	1,128	58.7%	555	27.9%	32	1.6%	283	13.2%	13	0.7%	1,991	100.0%
	OTHER MENTAL	1,064	29.7%	1,845	48.0%	51	1.4%	804	22.5%	14	0.4%	3,578	100.0%
	PHYSICAL	1,391	43.2%	1,047	32.5%	850	20.2%	130	4.0%	4	0.1%	3,222	100.0%
	TOTAL ALL CATEGORIES	3,583	40.8%	3,247	36.9%	733	8.3%	1,197	13.6%	31	0.4%	8,791	100.0%
CONNECTICUT	MENTAL RETARDATION	859	69.4%	27	2.2%	8	0.6%	327	28.4%	18	1.3%	1,237	100.0%
	OTHER MENTAL	408	47.8%	17	2.0%	27	3.2%	388	45.0%	19	2.2%	857	100.0%
	PHYSICAL	1,204	53.5%	348	15.4%	217	9.6%	484	20.6%	19	0.8%	2,250	100.0%
	TOTAL ALL CATEGORIES	2,471	56.9%	390	9.0%	252	5.8%	1,177	27.1%	54	1.2%	4,344	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
DELAWARE	MENTAL RETARDATION	410	75.0%	22	4.0%	3	0.5%	108	19.7%	4	0.7%	547	100.0%
	OTHER MENTAL	348	62.2%	14	2.5%	3	0.5%	185	33.3%	8	1.4%	558	100.0%
	PHYSICAL	370	50.1%	71	9.6%	283	35.8%	33	4.6%	2	0.3%	739	100.0%
	TOTAL ALL CATEGORIES	1,126	61.1%	107	6.8%	269	14.6%	326	17.7%	14	0.8%	1,842	100.0%
DISTRICT OF COLUMBIA	MENTAL RETARDATION	652	72.1%	25	2.8%	17	1.9%	209	23.1%	1	0.1%	904	100.0%
	OTHER MENTAL	216	42.9%	25	5.0%	42	8.3%	218	42.9%	5	1.0%	504	100.0%
	PHYSICAL	468	46.9%	98	9.6%	368	38.9%	63	8.3%	2	0.2%	997	100.0%
	TOTAL ALL CATEGORIES	1,336	55.6%	148	6.1%	427	17.8%	488	20.3%	8	0.3%	2,405	100.0%
FLORIDA	MENTAL RETARDATION	14,467	79.3%	227	1.2%	203	1.1%	3,293	18.1%	52	0.3%	18,242	100.0%
	OTHER MENTAL	7,683	60.0%	158	1.2%	252	2.0%	4,648	38.3%	74	0.6%	12,815	100.0%
	PHYSICAL	8,848	58.8%	1,650	11.0%	3,604	23.9%	888	5.9%	62	0.4%	15,050	100.0%
	TOTAL ALL CATEGORIES	30,998	67.2%	2,035	4.4%	4,059	8.8%	8,827	19.1%	188	0.4%	46,107	100.0%
GEORGIA	MENTAL RETARDATION	8,227	79.5%	154	2.0%	148	1.9%	1,280	16.3%	20	0.3%	7,829	100.0%
	OTHER MENTAL	3,144	54.3%	207	3.6%	214	3.7%	2,203	38.1%	17	0.3%	5,785	100.0%
	PHYSICAL	4,268	52.9%	1,347	16.7%	1,961	24.3%	469	5.8%	18	0.2%	8,063	100.0%
	TOTAL ALL CATEGORIES	13,639	62.9%	1,708	7.9%	2,323	10.7%	3,952	18.2%	55	0.3%	21,677	100.0%
HAWAII	MENTAL RETARDATION	181	87.9%	10	4.9%	2	1.0%	13	6.3%	0	0.0%	208	100.0%
	OTHER MENTAL	137	65.6%	14	6.7%	5	2.4%	52	24.9%	1	0.5%	209	100.0%
	PHYSICAL	327	83.4%	43	11.0%	13	3.3%	8	2.0%	1	0.3%	392	100.0%
	TOTAL ALL CATEGORIES	645	79.9%	67	8.3%	20	2.5%	73	9.0%	2	0.2%	807	100.0%
IDAHO	MENTAL RETARDATION	642	52.5%	57	4.7%	35	2.9%	460	37.6%	29	2.4%	1,223	100.0%
	OTHER MENTAL	494	33.7%	77	5.3%	35	2.4%	843	57.6%	15	1.0%	1,464	100.0%
	PHYSICAL	551	45.3%	197	16.2%	222	18.2%	235	19.3%	12	1.0%	1,217	100.0%
	TOTAL ALL CATEGORIES	1,687	43.2%	331	8.5%	292	7.5%	1,538	39.4%	56	1.4%	3,904	100.0%
ILLINOIS	MENTAL RETARDATION	13,913	60.0%	414	1.8%	49	0.2%	8,613	37.2%	183	0.8%	23,172	100.0%
	OTHER MENTAL	4,668	46.8%	210	2.1%	61	0.6%	4,992	49.9%	78	0.8%	10,009	100.0%
	PHYSICAL	6,013	45.4%	2,418	18.3%	2,835	21.4%	1,898	14.3%	72	0.5%	13,234	100.0%
	TOTAL ALL CATEGORIES	24,594	53.0%	3,040	6.5%	2,945	6.3%	15,503	33.4%	333	0.7%	46,415	100.0%
INDIANA	MENTAL RETARDATION	4,503	55.1%	284	3.6%	27	0.3%	3,288	40.2%	59	0.7%	8,171	100.0%
	OTHER MENTAL	1,333	33.1%	382	9.5%	69	1.7%	2,203	54.8%	46	1.1%	4,033	100.0%
	PHYSICAL	2,468	47.8%	1,089	21.1%	1,049	20.3%	522	10.1%	30	0.6%	5,158	100.0%
	TOTAL ALL CATEGORIES	8,304	47.8%	1,765	10.2%	1,145	6.6%	6,013	34.6%	135	0.8%	17,362	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
IOWA	MENTAL RETARDATION	1,544	80.3%	25	1.0%	28	1.0%	828	38.2%	38	1.5%	2,561	100.0%
	OTHER MENTAL	1,381	59.7%	19	0.8%	65	2.8%	820	35.5%	28	1.2%	2,313	100.0%
	PHYSICAL	1,258	55.6%	335	14.8%	493	21.8%	158	6.9%	21	0.9%	2,263	100.0%
	TOTAL ALL CATEGORIES	4,183	58.6%	379	5.3%	584	8.2%	1,804	26.7%	87	1.2%	7,137	100.0%
KANSAS	MENTAL RETARDATION	1,498	55.8%	195	7.2%	98	3.6%	882	32.0%	41	1.5%	2,892	100.0%
	OTHER MENTAL	1,182	41.5%	208	7.4%	80	2.8%	1,320	47.5%	21	0.8%	2,788	100.0%
	PHYSICAL	1,178	45.1%	503	19.3%	524	20.1%	398	15.2%	9	0.3%	2,610	100.0%
	TOTAL ALL CATEGORIES	3,858	47.4%	904	11.2%	702	8.7%	2,587	31.9%	71	0.9%	8,100	100.0%
KENTUCKY	MENTAL RETARDATION	3,509	48.5%	101	1.4%	48	0.7%	3,542	49.0%	34	0.5%	7,234	100.0%
	OTHER MENTAL	1,752	29.8%	52	0.9%	177	3.0%	3,873	88.0%	17	0.3%	5,871	100.0%
	PHYSICAL	2,458	48.8%	591	11.3%	1,351	25.7%	839	18.0%	12	0.2%	5,251	100.0%
	TOTAL ALL CATEGORIES	7,719	42.1%	744	4.1%	1,576	8.6%	8,264	45.0%	63	0.3%	18,358	100.0%
LOUISIANA	MENTAL RETARDATION	7,935	49.3%	158	1.0%	87	0.4%	7,883	49.0%	81	0.4%	18,102	100.0%
	OTHER MENTAL	3,521	32.4%	87	0.8%	79	0.7%	7,121	65.8%	53	0.5%	10,881	100.0%
	PHYSICAL	3,980	42.3%	1,146	12.2%	1,735	18.4%	2,503	28.8%	45	0.5%	9,409	100.0%
	TOTAL ALL CATEGORIES	15,436	42.4%	1,389	3.8%	1,881	5.2%	17,507	48.1%	159	0.4%	36,372	100.0%
MAINE	MENTAL RETARDATION	388	77.4%	41	8.7%	10	2.1%	55	11.8%	1	0.2%	473	100.0%
	OTHER MENTAL	391	63.8%	76	12.4%	12	2.0%	133	21.7%	1	0.2%	613	100.0%
	PHYSICAL	628	82.7%	177	17.7%	112	11.2%	82	8.2%	2	0.2%	1,001	100.0%
	TOTAL ALL CATEGORIES	1,385	68.4%	294	14.1%	134	6.4%	270	12.9%	4	0.2%	2,087	100.0%
MARYLAND	MENTAL RETARDATION	2,381	88.1%	101	2.9%	54	1.6%	942	27.2%	11	0.3%	3,489	100.0%
	OTHER MENTAL	1,423	44.8%	88	2.8%	82	1.9%	1,811	50.5%	7	0.2%	3,191	100.0%
	PHYSICAL	2,097	57.4%	473	12.9%	810	22.2%	272	7.4%	1	0.0%	3,653	100.0%
	TOTAL ALL CATEGORIES	5,881	57.0%	662	8.4%	926	9.0%	2,825	27.4%	19	0.2%	10,313	100.0%
MASSACHUSETTS	MENTAL RETARDATION	1,915	54.5%	373	10.8%	104	3.0%	1,037	29.5%	83	2.4%	3,512	100.0%
	OTHER MENTAL	2,134	45.9%	288	6.1%	129	2.8%	1,931	41.5%	172	3.7%	4,652	100.0%
	PHYSICAL	3,685	58.2%	1,077	17.5%	835	13.8%	583	9.5%	77	1.3%	6,157	100.0%
	TOTAL ALL CATEGORIES	7,634	53.3%	1,738	12.1%	1,068	7.5%	3,551	24.8%	332	2.3%	14,321	100.0%
MICHIGAN	MENTAL RETARDATION	8,952	80.1%	508	3.4%	257	1.7%	5,029	33.7%	157	1.1%	14,801	100.0%
	OTHER MENTAL	4,842	37.2%	481	3.8%	327	2.8%	8,845	54.9%	172	1.4%	12,487	100.0%
	PHYSICAL	4,425	49.2%	1,447	16.1%	1,870	20.8%	1,200	13.3%	61	0.6%	8,993	100.0%
	TOTAL ALL CATEGORIES	18,019	49.8%	2,434	8.7%	2,454	8.7%	13,074	38.0%	380	1.0%	36,361	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
MINNESOTA	MENTAL RETARDATION	1,890	69.7%	270	8.6%	22	0.7%	921	29.1%	62	2.0%	3,165	100.0%
	OTHER MENTAL	804	33.9%	243	9.3%	34	1.3%	1,418	64.4%	27	1.0%	2,808	100.0%
	PHYSICAL	2,023	48.4%	481	11.6%	1,062	26.4%	807	14.6%	7	0.2%	4,180	100.0%
	TOTAL ALL CATEGORIES	4,707	48.2%	804	10.0%	1,118	11.2%	2,040	20.8%	98	1.0%	9,951	100.0%
MISSISSIPPI	MENTAL RETARDATION	4,648	42.6%	684	6.3%	188	1.7%	5,318	49.8%	68	0.6%	10,682	100.0%
	OTHER MENTAL	811	21.2%	192	6.0%	101	2.6%	2,882	70.3%	31	0.8%	3,817	100.0%
	PHYSICAL	2,105	31.7%	1,668	24.2%	1,709	24.8%	1,304	18.9%	31	0.4%	6,895	100.0%
	TOTAL ALL CATEGORIES	7,564	35.3%	2,422	11.3%	1,998	9.3%	9,302	43.6%	130	0.8%	21,394	100.0%
MISSOURI	MENTAL RETARDATION	3,652	68.7%	399	8.4%	69	0.9%	2,168	34.4%	103	1.6%	8,269	100.0%
	OTHER MENTAL	1,823	31.4%	460	7.8%	221	3.8%	3,182	64.8%	124	2.1%	6,810	100.0%
	PHYSICAL	2,687	52.4%	800	15.6%	878	17.2%	717	14.0%	41	0.8%	5,124	100.0%
	TOTAL ALL CATEGORIES	8,062	48.9%	1,659	9.8%	1,159	8.7%	6,055	35.2%	268	1.6%	17,203	100.0%
MONTANA	MENTAL RETARDATION	408	71.4%	34	8.0%	6	0.9%	123	21.6%	1	0.2%	689	100.0%
	OTHER MENTAL	271	63.8%	13	2.6%	1	0.2%	218	42.9%	3	0.8%	604	100.0%
	PHYSICAL	413	68.2%	127	17.9%	123	17.3%	46	8.3%	2	0.3%	710	100.0%
	TOTAL ALL CATEGORIES	1,090	61.1%	174	9.8%	129	7.2%	384	21.6%	8	0.3%	1,783	100.0%
NEBRASKA	MENTAL RETARDATION	809	64.1%	80	8.3%	23	1.8%	328	28.1%	21	1.7%	1,282	100.0%
	OTHER MENTAL	265	33.3%	27	3.6%	22	2.8%	463	69.1%	9	1.2%	788	100.0%
	PHYSICAL	728	64.0%	166	12.3%	338	26.0%	112	8.3%	8	0.4%	1,345	100.0%
	TOTAL ALL CATEGORIES	1,790	63.1%	272	8.1%	381	11.3%	894	28.6%	38	1.1%	3,373	100.0%
NEVADA	MENTAL RETARDATION	430	78.0%	38	8.7%	14	2.6%	80	14.1%	4	0.7%	688	100.0%
	OTHER MENTAL	297	64.4%	46	8.2%	32	6.8%	187	30.8%	6	0.9%	648	100.0%
	PHYSICAL	735	68.1%	240	18.3%	280	21.4%	51	3.9%	6	0.4%	1,311	100.0%
	TOTAL ALL CATEGORIES	1,462	60.3%	323	13.3%	326	13.6%	298	12.3%	14	0.6%	2,423	100.0%
NEW HAMPSHIRE	MENTAL RETARDATION	384	76.4%	68	12.0%	20	4.1%	41	8.6%	0	0.0%	483	100.0%
	OTHER MENTAL	193	66.8%	60	17.3%	26	7.2%	87	18.3%	2	0.6%	347	100.0%
	PHYSICAL	621	78.8%	90	13.6%	30	4.6%	18	2.7%	2	0.3%	681	100.0%
	TOTAL ALL CATEGORIES	1,078	72.3%	208	14.0%	76	6.0%	128	8.6%	4	0.3%	1,401	100.0%
NEW JERSEY	MENTAL RETARDATION	3,417	88.4%	408	7.9%	79	1.6%	1,191	23.1%	68	1.1%	5,149	100.0%
	OTHER MENTAL	2,086	34.4%	468	7.8%	172	2.9%	3,187	63.1%	109	1.8%	8,001	100.0%
	PHYSICAL	3,400	44.6%	2,493	32.7%	1,019	13.4%	873	8.8%	41	0.6%	7,826	100.0%
	TOTAL ALL CATEGORIES	8,882	47.3%	3,387	17.9%	1,270	6.8%	5,051	26.9%	206	1.1%	18,778	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
NEW MEXICO	MENTAL RETARDATION	799	57.9%	112	8.1%	40	2.9%	422	30.6%	8	0.4%	1,379	100.0%
	OTHER MENTAL	669	43.1%	229	14.8%	60	3.9%	588	37.8%	7	0.5%	1,551	100.0%
	PHYSICAL	983	41.4%	552	23.3%	494	20.8%	337	14.2%	7	0.3%	2,373	100.0%
	TOTAL ALL CATEGORIES	2,451	46.2%	893	16.8%	594	11.2%	1,345	25.4%	20	0.4%	5,303	100.0%
NEW YORK	MENTAL RETARDATION	14,895	55.8%	1,378	5.2%	600	2.2%	9,362	35.1%	439	1.6%	28,674	100.0%
	OTHER MENTAL	7,083	30.2%	1,305	5.6%	1,027	4.4%	13,545	57.8%	484	2.1%	23,444	100.0%
	PHYSICAL	9,522	47.6%	4,632	22.7%	2,235	11.2%	3,508	17.5%	200	1.0%	19,997	100.0%
	TOTAL ALL CATEGORIES	31,500	44.9%	7,215	10.3%	3,862	5.5%	28,415	37.7%	1,123	1.6%	70,115	100.0%
NORTH CAROLINA	MENTAL RETARDATION	4,744	47.6%	104	1.0%	55	0.8%	5,031	50.5%	33	0.3%	9,967	100.0%
	OTHER MENTAL	1,178	21.3%	47	0.9%	78	1.4%	4,189	75.8%	33	0.6%	5,525	100.0%
	PHYSICAL	3,818	48.3%	983	12.4%	1,885	23.8%	1,205	15.2%	20	0.3%	7,911	100.0%
	TOTAL ALL CATEGORIES	9,740	41.6%	1,134	4.8%	2,018	8.6%	10,425	44.5%	86	0.4%	23,403	100.0%
NORTH DAKOTA	MENTAL RETARDATION	278	75.8%	8	2.2%	1	0.3%	70	19.2%	10	2.7%	365	100.0%
	OTHER MENTAL	148	57.9%	9	3.6%	4	1.6%	89	35.3%	4	1.6%	252	100.0%
	PHYSICAL	238	58.9%	85	21.2%	83	15.7%	14	3.5%	3	0.7%	401	100.0%
	TOTAL ALL CATEGORIES	658	64.6%	102	10.0%	68	6.7%	173	17.0%	17	1.7%	1,018	100.0%
OHIO	MENTAL RETARDATION	13,338	67.9%	1,305	8.6%	191	1.0%	4,723	24.1%	73	0.4%	19,628	100.0%
	OTHER MENTAL	7,832	51.4%	1,874	11.0%	251	1.6%	5,395	35.4%	72	0.5%	15,224	100.0%
	PHYSICAL	6,076	58.6%	2,259	21.8%	1,246	12.0%	775	7.5%	22	0.2%	10,377	100.0%
	TOTAL ALL CATEGORIES	27,244	60.2%	5,238	11.6%	1,687	3.7%	10,893	24.1%	167	0.4%	45,229	100.0%
OKLAHOMA	MENTAL RETARDATION	3,127	75.0%	49	1.2%	28	0.6%	981	23.0%	8	0.2%	4,171	100.0%
	OTHER MENTAL	1,298	65.6%	35	1.8%	31	1.8%	811	30.9%	4	0.2%	1,979	100.0%
	PHYSICAL	2,007	68.0%	618	20.2%	305	10.0%	109	3.6%	5	0.2%	3,042	100.0%
	TOTAL ALL CATEGORIES	6,432	70.0%	700	7.6%	362	3.9%	1,681	18.3%	17	0.2%	9,192	100.0%
OREGON	MENTAL RETARDATION	1,168	72.4%	107	8.8%	23	1.4%	293	18.2%	21	1.3%	1,610	100.0%
	OTHER MENTAL	895	58.7%	48	2.7%	70	4.1%	564	33.3%	19	1.1%	1,894	100.0%
	PHYSICAL	1,836	72.5%	165	8.5%	427	18.9%	89	3.9%	6	0.2%	2,533	100.0%
	TOTAL ALL CATEGORIES	3,997	68.5%	318	5.4%	520	8.9%	956	18.4%	46	0.8%	6,837	100.0%
PENNSYLVANIA	MENTAL RETARDATION	8,021	58.8%	888	8.5%	221	1.8%	4,373	32.0%	144	1.1%	13,647	100.0%
	OTHER MENTAL	4,238	34.2%	699	5.6%	383	3.1%	6,977	58.3%	105	0.8%	12,402	100.0%
	PHYSICAL	4,818	48.6%	2,182	21.2%	2,122	20.5%	1,145	11.1%	61	0.6%	10,338	100.0%
	TOTAL ALL CATEGORIES	17,077	46.9%	3,779	10.4%	2,726	7.5%	12,495	34.3%	310	0.9%	36,387	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC.*	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
RHODE ISLAND	MENTAL RETARDATION	497	69.7%	29	4.1%	8	1.1%	174	24.4%	6	0.7%	713	100.0%
	OTHER MENTAL	260	39.0%	24	3.8%	12	1.8%	368	55.0%	4	0.6%	668	100.0%
	PHYSICAL	419	68.8%	47	7.5%	113	18.0%	42	8.7%	8	1.0%	627	100.0%
	TOTAL ALL CATEGORIES	1,176	58.8%	100	5.0%	133	8.6%	582	29.0%	15	0.7%	2,008	100.0%
SOUTH CAROLINA	MENTAL RETARDATION	4,470	72.7%	94	1.5%	59	1.0%	1,507	24.5%	21	0.3%	8,151	100.0%
	OTHER MENTAL	1,383	45.5%	72	2.4%	37	1.2%	1,535	50.5%	11	0.4%	3,038	100.0%
	PHYSICAL	2,575	52.0%	722	14.6%	1,031	20.8%	811	12.3%	17	0.3%	4,958	100.0%
	TOTAL ALL CATEGORIES	8,428	59.6%	888	6.3%	1,127	8.0%	3,653	25.8%	49	0.3%	14,145	100.0%
SOUTH DAKOTA	MENTAL RETARDATION	440	60.4%	5	0.7%	15	2.1%	248	33.7%	23	3.2%	729	100.0%
	OTHER MENTAL	222	41.2%	2	0.4%	17	3.2%	285	52.9%	13	2.4%	539	100.0%
	PHYSICAL	477	63.1%	70	7.8%	248	27.4%	100	11.1%	5	0.6%	898	100.0%
	TOTAL ALL CATEGORIES	1,139	52.6%	77	3.6%	278	12.8%	631	29.1%	41	1.8%	2,168	100.0%
TENNESSEE	MENTAL RETARDATION	5,962	71.2%	258	3.1%	57	0.7%	2,081	24.8%	33	0.4%	8,371	100.0%
	OTHER MENTAL	2,448	51.9%	200	4.2%	72	1.5%	1,959	41.8%	33	0.7%	4,710	100.0%
	PHYSICAL	2,755	58.8%	714	15.2%	875	18.8%	338	7.1%	24	0.5%	4,704	100.0%
	TOTAL ALL CATEGORIES	11,163	62.8%	1,172	8.6%	1,004	5.6%	4,358	24.5%	80	0.5%	17,785	100.0%
TEXAS	MENTAL RETARDATION	10,208	85.5%	95	0.8%	71	0.5%	5,007	32.1%	198	1.3%	15,577	100.0%
	OTHER MENTAL	2,940	29.5%	109	1.1%	269	2.7%	8,408	65.0%	172	1.7%	8,085	100.0%
	PHYSICAL	10,855	62.4%	1,048	11.2%	2,659	15.3%	1,828	10.5%	107	0.6%	17,397	100.0%
	TOTAL ALL CATEGORIES	24,012	55.0%	2,152	5.0%	2,999	7.0%	13,331	31.0%	475	1.1%	42,869	100.0%
UTAH	MENTAL RETARDATION	819	68.3%	40	3.3%	18	1.3%	310	25.9%	14	1.2%	1,199	100.0%
	OTHER MENTAL	663	50.8%	33	2.5%	40	3.1%	581	43.0%	9	0.7%	1,308	100.0%
	PHYSICAL	1,092	65.2%	211	12.8%	169	10.1%	199	11.9%	4	0.2%	1,875	100.0%
	TOTAL ALL CATEGORIES	2,574	61.6%	284	6.8%	225	5.4%	1,070	25.8%	27	0.6%	4,180	100.0%
VERMONT	MENTAL RETARDATION	132	44.9%	82	21.1%	14	4.8%	12	4.1%	74	25.2%	294	100.0%
	OTHER MENTAL	116	20.5%	78	13.8%	18	3.2%	65	11.5%	290	51.1%	587	100.0%
	PHYSICAL	220	53.9%	87	21.3%	81	15.0%	10	2.5%	30	7.4%	408	100.0%
	TOTAL ALL CATEGORIES	468	36.8%	227	17.9%	93	7.3%	87	6.8%	394	31.0%	1,269	100.0%
VIRGINIA	MENTAL RETARDATION	3,855	57.8%	200	3.0%	34	0.5%	2,538	38.1%	37	0.6%	6,884	100.0%
	OTHER MENTAL	2,019	30.0%	77	1.1%	69	1.0%	4,554	67.8%	21	0.3%	6,740	100.0%
	PHYSICAL	3,022	58.7%	594	11.5%	1,043	20.3%	475	9.2%	13	0.3%	5,147	100.0%
	TOTAL ALL CATEGORIES	8,896	48.0%	871	4.7%	1,146	8.2%	7,567	40.8%	71	0.4%	18,651	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
IMPAIRMENT GROUPINGS BY NATION AND STATE
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

STATE	IMPAIRMENT CATEGORY	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC.*	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
WASHINGTON	MENTAL RETARDATION	1,863	68.0%	140	5.0%	68	2.4%	720	25.5%	32	1.1%	2,823	100.0%
	OTHER MENTAL	1,575	48.0%	90	2.6%	123	3.6%	1,608	48.8%	30	0.8%	3,428	100.0%
	PHYSICAL	2,488	54.3%	529	11.5%	920	20.1%	832	13.8%	18	0.3%	4,585	100.0%
	TOTAL ALL CATEGORIES	5,926	54.7%	759	7.0%	1,111	10.3%	2,960	27.3%	78	0.7%	10,834	100.0%
WEST VIRGINIA	MENTAL RETARDATION	2,082	81.5%	113	3.4%	58	1.7%	1,093	32.6%	31	0.8%	3,355	100.0%
	OTHER MENTAL	874	48.3%	27	1.5%	43	2.4%	854	47.2%	11	0.6%	1,809	100.0%
	PHYSICAL	1,167	55.5%	201	9.6%	383	18.2%	344	18.3%	9	0.4%	2,104	100.0%
	TOTAL ALL CATEGORIES	4,103	58.5%	341	4.7%	482	8.8%	2,291	31.5%	51	0.7%	7,268	100.0%
WISCONSIN	MENTAL RETARDATION	2,824	49.3%	943	18.5%	88	1.5%	1,854	32.3%	23	0.4%	5,732	100.0%
	OTHER MENTAL	2,178	28.6%	992	12.1%	184	2.2%	4,790	58.5%	44	0.5%	8,188	100.0%
	PHYSICAL	2,840	40.4%	1,375	21.1%	1,778	27.2%	728	11.1%	11	0.2%	8,530	100.0%
	TOTAL ALL CATEGORIES	7,840	37.4%	3,310	18.2%	2,050	10.0%	7,370	38.0%	78	0.4%	20,448	100.0%
WYOMING	MENTAL RETARDATION	123	47.3%	19	7.3%	2	0.8%	89	38.1%	17	8.5%	280	100.0%
	OTHER MENTAL	118	28.2%	12	2.7%	21	4.7%	285	83.2%	15	3.3%	451	100.0%
	PHYSICAL	176	49.7%	82	23.2%	48	13.0%	47	13.3%	3	0.8%	354	100.0%
	TOTAL ALL CATEGORIES	417	38.2%	113	10.6%	69	8.5%	431	40.5%	35	3.3%	1,085	100.0%
OTHER**	MENTAL RETARDATION	338	80.9%	19	4.5%	1	0.2%	37	8.8%	23	5.5%	418	100.0%
	OTHER MENTAL	130	49.1%	23	8.7%	8	2.3%	81	30.8%	25	9.4%	285	100.0%
	PHYSICAL	249	63.4%	70	17.8%	34	8.7%	28	8.6%	14	3.8%	303	100.0%
	TOTAL ALL CATEGORIES	717	68.8%	112	10.4%	41	3.8%	144	13.4%	62	5.8%	1,078	100.0%

SOURCE: SSA-831 FILE - YEARS 1991 - 1994
PREPARED BY: SOCIAL SECURITY ADMINISTRATION
DATE PREPARED: 2/95

NOTES:

* INCLUDES ALLOWANCES BASED ON MEDICAL/VOCATIONAL CRITERIA (E.G., DISABLED CHILDREN AGE 18 AND OVER), AS WELL AS ALLOWANCES WHERE NO BASIS VALID CODE WAS RECORDED.

** INCLUDES OFFICE OF INTERNATIONAL OPERATIONS CASES, FEDERAL DDS CASES, AND NORTHERN MARIANAS ISLANDS CASES AS WELL AS CASES WITH INVALID DDS CODES.

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

IMPAIRMENT	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
0110-PULMONARY TUBERCULOSIS	6	28.6%	4	19.0%	2	9.5%	8	38.1%	1	4.8%	21	100.0%
0300-LEPROSY	4	40.0%	1	10.0%	4	40.0%	1	10.0%	0	0.0%	10	100.0%
0430-SYMPTOMATIC HIV POSITIVE	735	28.8%	1,490	60.3%	122	4.8%	102	4.1%	20	0.8%	2,469	100.0%
0440-ASYMPTOMATIC HIV POSITIVE	22	15.4%	82	57.3%	9	6.3%	27	18.9%	3	2.1%	143	100.0%
0930-CARDIOVAS SYPHILIS	0	0.0%	2	66.7%	1	33.3%	0	0.0%	0	0.0%	3	100.0%
0940-NEUROSYPHILIS	6	75.0%	0	0.0%	1	12.5%	1	12.5%	0	0.0%	8	100.0%
1170-MYCOTIC INFEC	28	45.9%	17	27.9%	7	11.5%	9	14.8%	0	0.0%	61	100.0%
1350-SARCOIDOSIS	1	3.8%	6	23.1%	1	3.8%	18	69.2%	0	0.0%	26	100.0%
1360-OTHER INFEC/PARA DIS	87	39.4%	61	27.6%	22	10.0%	49	22.2%	2	0.9%	221	100.0%
1380-LATE EFF ACUTE POLIO	92	53.5%	21	12.2%	11	6.4%	39	22.7%	9	5.2%	172	100.0%
1410-MAL NEOPL/TONGUE	3	37.5%	2	25.0%	1	12.5%	2	25.0%	0	0.0%	8	100.0%
1420-MAL NEOPL/SALIV GLAND	2	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	2	100.0%
1500-MAL NEOPL/ESOPHAGUS	3	75.0%	0	0.0%	0	0.0%	1	25.0%	0	0.0%	4	100.0%
1510-MAL NEOPL/STOMACH	22	84.6%	1	3.8%	2	7.7%	1	3.8%	0	0.0%	26	100.0%
1520-MAL NEOPL/SM INTEST	4	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	100.0%
1530-MAL NEOPL/COLON,RECTUM,ANUS	19	79.2%	3	12.5%	2	8.3%	0	0.0%	0	0.0%	24	100.0%
1550-MAL NEOPL/LIVER	95	87.2%	14	12.8%	0	0.0%	0	0.0%	0	0.0%	109	100.0%
1560-MAL NEOPL/GALLBLADDER	2	33.3%	3	50.0%	1	16.7%	0	0.0%	0	0.0%	6	100.0%
1570-MAL NEOPL/PANCREAS	4	50.0%	4	50.0%	0	0.0%	0	0.0%	0	0.0%	8	100.0%
1590-MAL NEOPL/OTH DIGES,PERITON	50	75.8%	15	22.7%	0	0.0%	1	1.5%	0	0.0%	66	100.0%
1620-MAL NEOPL/TRACHEA,BRONCHUS,LUNG	41	78.8%	6	11.5%	4	7.7%	1	1.9%	0	0.0%	52	100.0%
1630-MAL NEOPL/PLEURA	1	50.0%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	2	100.0%
1640-MAL NEOPL/THYMUS,HEART,MEDIAST	10	66.7%	3	20.0%	2	13.3%	0	0.0%	0	0.0%	15	100.0%
1700-MAL NEOPL/BONE ARTIC CARTILAGE	238	81.8%	40	13.7%	7	2.4%	6	2.1%	0	0.0%	291	100.0%
1710-MAL NEOPL/CONNEC,SOFT TISSUE	97	82.2%	17	14.4%	1	0.8%	1	0.8%	2	1.7%	118	100.0%
1720-MAL MELANOMA OF SKIN	18	69.2%	7	26.9%	1	3.8%	0	0.0%	0	0.0%	26	100.0%
1730-OTH MAL NEOPLASM OF SKIN	56	83.6%	8	11.9%	1	1.5%	2	3.0%	0	0.0%	67	100.0%
1740-MAL NEOPL/BREAST	9	64.3%	3	21.4%	1	7.1%	1	7.1%	0	0.0%	14	100.0%
1790-MAL NEOPL/UTERUS	9	60.0%	3	20.0%	1	6.7%	2	13.3%	0	0.0%	15	100.0%
1830-MAL NEOPL/OVARY,UTERINE ADNEXA	54	62.8%	11	12.8%	20	23.3%	0	0.0%	1	1.2%	86	100.0%
1840-MAL NEOPL/OTH FEM GEN ORGANS	9	58.3%	3	18.8%	2	12.5%	2	12.5%	0	0.0%	16	100.0%
1850-MAL NEOPL/PROSTATE	5	83.3%	1	16.7%	0	0.0%	0	0.0%	0	0.0%	6	100.0%
1860-MAL NEOPL/TESTIS	39	90.7%	4	9.3%	0	0.0%	0	0.0%	0	0.0%	43	100.0%
1870-MAL NEOPL/PENIS,& MALE GEN ORG	5	55.6%	1	11.1%	0	0.0%	3	33.3%	0	0.0%	9	100.0%
1880-MAL NEOPL/BLADDER	14	93.3%	1	6.7%	0	0.0%	0	0.0%	0	0.0%	15	100.0%
1890-MAL NEOPL/KIDNEY,OTH URINARY	255	91.4%	17	6.1%	2	0.7%	5	1.8%	0	0.0%	279	100.0%
1900-MAL NEOPL/EYE	218	83.2%	31	11.8%	3	1.1%	7	2.7%	3	1.1%	262	100.0%
1910-MAL NEOPL/BRAIN	1,356	73.2%	384	20.7%	34	1.8%	69	3.7%	10	0.5%	1,853	100.0%
1920-MAL NEOPL/OTH PARTS NERV SYS	758	91.2%	64	7.7%	4	0.5%	4	0.5%	1	0.1%	831	100.0%
1930-MAL NEOPL/THYROID GLAND	17	73.9%	4	17.4%	1	4.3%	1	4.3%	0	0.0%	23	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

IMPAIRMENT	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC.*	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
1940-MAL NEOPL/OTH ENDOCRINE	28	72.2%	7	19.4%	0	0.0%	3	8.3%	0	0.0%	38	100.0%
1950-MAL NEOPL/OTHER SITES	118	71.5%	31	18.8%	12	7.3%	4	2.4%	0	0.0%	165	100.0%
1980-MAL NEOPL/DISTANT SITES	21	80.8%	3	11.5%	0	0.0%	2	7.7%	0	0.0%	28	100.0%
1990-MAL NEOPL/UNSPEC SITES	1,828	90.3%	178	8.7%	14	0.7%	3	0.1%	3	0.1%	2,024	100.0%
2020-LYMPHOMA	940	80.4%	135	11.5%	35	3.0%	53	4.5%	8	0.5%	1,169	100.0%
2030-MULTIPLE MYELOMA	5	50.0%	3	30.0%	0	0.0%	2	20.0%	0	0.0%	10	100.0%
2070-LEUKEMIAS	4,502	91.1%	377	7.6%	13	0.3%	38	0.8%	10	0.2%	4,940	100.0%
2250-BEN NEOPL/BRAIN, NERV SYS	275	48.4%	141	24.8%	47	8.3%	101	17.8%	4	0.7%	568	100.0%
2380-NEOPL/UNCERTAIN BEHAVIOR	22	37.3%	15	25.4%	12	20.3%	10	18.9%	0	0.0%	59	100.0%
2390-NEOPL/UNSPEC/UNK BEHAVIOR	102	47.0%	12	5.5%	17	7.8%	84	38.7%	2	0.9%	217	100.0%
2460-DISORDERS OF THYROID	179	48.7%	69	18.0%	33	8.6%	98	25.6%	4	1.0%	383	100.0%
2500-DIABETES MELLITUS	808	58.3%	214	15.5%	69	5.0%	275	19.9%	18	1.3%	1,382	100.0%
2510-HYPOGLYCEMIA	21	42.9%	17	34.7%	8	16.3%	3	6.1%	0	0.0%	49	100.0%
2520-DISORDERS OF PARATHYROID	33	62.3%	17	32.1%	3	6.7%	0	0.0%	0	0.0%	63	100.0%
2530-DISORDERS OF PITUITARY	187	62.3%	66	24.6%	18	8.7%	13	4.9%	4	1.5%	268	100.0%
2550-DISORDERS OF ADRENAL	132	57.4%	60	26.1%	19	8.3%	19	8.3%	0	0.0%	230	100.0%
2630-MALNUTRITION/WGT LOSS	217	22.6%	409	42.6%	270	28.2%	60	6.3%	3	0.3%	959	100.0%
2730-DIS PLASMA PROTEIN METAB	4	50.0%	1	12.5%	0	0.0%	3	37.5%	0	0.0%	8	100.0%
2740-GOUT	6	40.0%	2	13.3%	2	13.3%	5	33.3%	0	0.0%	15	100.0%
2760-DIABETEC ACIDOSIS	22	52.4%	10	23.8%	5	11.9%	5	11.9%	0	0.0%	42	100.0%
2770-DIS META/CYSTIC FIBROSIS	980	45.7%	752	35.1%	197	9.2%	203	9.5%	11	0.5%	2,143	100.0%
2780-OBESITY	235	18.9%	703	60.6%	145	10.4%	300	21.8%	9	0.6%	1,392	100.0%
2790-DIS IMMUNE MECHANISM (EX HIV)	298	45.0%	283	39.7%	58	8.8%	40	6.0%	3	0.5%	882	100.0%
2810-DEFICIENCY ANEMIAS	23	43.4%	22	41.5%	4	7.5%	3	5.7%	1	1.8%	53	100.0%
2820-HERED HEMO ANEM. INCL SICKLE CL	5,513	79.0%	1,088	15.3%	142	2.0%	228	3.3%	27	0.4%	6,978	100.0%
2840-APLASTIC ANEMIA	113	31.5%	111	30.9%	45	12.5%	89	24.8%	1	0.3%	369	100.0%
2850-OTHER ANEMIAS	144	52.6%	89	32.5%	23	8.4%	14	5.1%	4	1.5%	274	100.0%
2860-COAGULATION DEFECTS	680	73.4%	144	15.8%	39	4.2%	61	6.8%	2	0.2%	926	100.0%
2870-PURPURA/OTH HEMOR COND	215	64.8%	80	24.1%	16	4.8%	21	6.3%	0	0.0%	332	100.0%
2880-DIS WHITE BLOOD CELLS	11	20.8%	32	60.4%	6	11.3%	4	7.5%	0	0.0%	53	100.0%
2890-OTH DIS BLOOD/BLOOD FORM ORG	71	46.4%	44	28.8%	11	7.2%	25	18.3%	2	1.3%	153	100.0%
2940-ORGANIC MENTAL DISORDERS	8,805	54.0%	1,097	6.7%	717	4.4%	5,474	33.6%	198	1.2%	18,291	100.0%
2950-SCHIZO/PARAN FUNC DISORDERS	4,385	68.8%	309	4.9%	111	1.7%	1,454	22.8%	111	1.7%	8,370	100.0%
2960-MOOD DISORDERS (CHILDREN)	10,123	41.9%	1,297	5.4%	533	2.2%	11,777	48.7%	428	1.8%	24,158	100.0%
2990-DVLPMENTAL DIS INCL AUTISM (CH)	9,468	63.1%	818	5.4%	293	2.0%	4,308	28.7%	123	0.8%	15,004	100.0%
3000-ANXIETY RELATED DISORDERS	5,557	37.5%	818	5.5%	431	2.8%	7,778	52.5%	242	1.6%	14,824	100.0%
3010-PERSONALITY DISORDERS	17,103	47.1%	2,254	6.2%	688	1.9%	15,731	43.4%	499	1.4%	36,275	100.0%
3030-SUBSTANCE DEPEND./ALCOHOL (CH)	251	44.3%	28	4.9%	10	1.8%	257	45.3%	21	3.7%	587	100.0%
3040-SUBSTANCE DEPEND./DRUGS (CH)	231	48.5%	34	8.8%	10	2.0%	211	42.5%	11	2.2%	497	100.0%
3060-SOMATOFORM DISORDERS	195	50.0%	34	8.7%	12	3.1%	145	37.2%	4	1.0%	390	100.0%

Appendix 7-F

97180 N/A + 102 MR
102 MR

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

IMPAIRMENT	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
3070-EATING AND TIC DISORDERS	484	46.7%	59	5.7%	37	3.8%	452	43.6%	4	0.4%	1,038	100.0%
3120-CONDUCT DISORDER (CH)	560	28.2%	134	6.8%	39	2.0%	1,238	62.3%	16	0.8%	1,985	100.0%
3138-OPPOSITIONAL/DEFIANT DISORDER (CH)	499	25.8%	169	8.7%	27	1.4%	1,228	63.4%	14	0.7%	1,937	100.0%
3140-ATTENTION DEFICIT HYPER DIS	25,789	39.8%	2,485	3.8%	1,002	1.5%	35,012	54.1%	461	0.7%	64,729	100.0%
3150-DEVELOP/EMOTIONAL DIS-INFANT	3,691	26.4%	995	7.1%	881	6.1%	8,279	59.1%	177	1.3%	14,003	100.0%
3152-LEARNING DISORDER (CH)	279	8.2%	81	2.4%	68	2.0%	2,935	86.6%	32	0.9%	3,395	100.0%
3153-SPEECH AND LANGUAGE DELAYS (CH)	198	8.1%	305	12.5%	305	12.5%	1,618	66.4%	12	0.5%	2,438	100.0%
3180-MENTAL RETARDATION	190,998	81.2%	12,783	4.1%	3,805	1.2%	101,589	32.6%	2,634	0.8%	311,889	100.0%
3300-CEREBRAL DEGEN/CHILDHOOD	961	57.0%	279	16.5%	268	15.8%	177	10.5%	3	0.2%	1,688	100.0%
3310-OTHER CEREBRAL DEGEN	298	55.7%	92	17.2%	58	10.8%	82	15.3%	5	0.9%	535	100.0%
3320-PARKINSONS DISEASE	93	85.3%	11	10.1%	3	2.8%	1	0.9%	1	0.9%	109	100.0%
3350-ANTERIOR HORN CELL DIS (ALS)	31	67.4%	5	10.9%	5	10.9%	5	10.9%	0	0.0%	46	100.0%
3360-OTH DIS OF SPINAL CORD	456	75.4%	75	12.4%	34	5.8%	37	6.1%	3	0.5%	605	100.0%
3370-DIS AUTONOMIC NERV SYS	61	46.9%	28	21.5%	9	6.9%	30	23.1%	2	1.5%	130	100.0%
3400-MULTIPLE SCLEROSIS	88	57.5%	27	17.6%	10	6.5%	28	17.0%	2	1.3%	153	100.0%
3430-CEREBRAL PALSY	17,970	82.5%	1,622	7.4%	488	2.2%	1,597	7.3%	96	0.4%	21,773	100.0%
3450-EPILEPSY	6,248	63.5%	1,343	13.7%	364	3.7%	1,824	18.5%	56	0.6%	9,835	100.0%
3460-MIGRAINE	22	26.5%	25	30.1%	8	9.6%	28	31.3%	2	2.4%	83	100.0%
3490-OTHER NERV SYS DISORDERS	9,088	72.7%	1,429	11.4%	669	5.3%	1,252	10.0%	70	0.6%	12,508	100.0%
3570-DIABETIC/PERI NEUROPATHY	72	59.0%	17	13.9%	12	9.8%	18	14.8%	3	2.5%	122	100.0%
3580-MYONEURAL DISORDERS	114	45.6%	43	17.2%	29	11.6%	62	24.8%	2	0.8%	250	100.0%
3590-MUSCULAR DYSTROPHIES	1,002	67.0%	173	11.6%	89	4.8%	238	15.9%	13	0.9%	1,495	100.0%
3610-RETINAL DETACH/DEFECTS	252	69.6%	58	16.5%	8	2.2%	44	12.2%	2	0.6%	382	100.0%
3620-OTHER RETINAL DISORDERS	144	65.5%	21	9.5%	14	6.4%	40	18.2%	1	0.5%	220	100.0%
3650-GLAUCOMA	128	54.7%	44	18.8%	16	6.8%	39	16.7%	7	3.0%	234	100.0%
3660-CATARACT	215	55.7%	48	12.4%	36	9.3%	82	21.2%	5	1.3%	386	100.0%
3680-VISUAL DISTURBANCES	528	49.7%	184	17.3%	73	6.9%	268	25.2%	10	0.9%	1,063	100.0%
3690-BLINDNESS/LOW VISION	7,339	77.0%	1,363	14.3%	238	2.5%	558	5.9%	35	0.4%	9,533	100.0%
3780-STRABISMUS/DIS EYE MOVE	115	44.7%	28	10.9%	8	3.1%	102	39.7%	4	1.6%	257	100.0%
3860-VERTIGINOUS SYNDROMES	13	31.7%	11	26.8%	1	2.4%	18	39.0%	0	0.0%	41	100.0%
3880-OTHER EAR DISORDERS	151	33.3%	84	14.1%	37	8.1%	196	43.2%	6	1.3%	454	100.0%
3890-DEAFNESS	10,244	70.0%	2,036	13.9%	488	3.3%	1,807	12.3%	63	0.4%	14,636	100.0%
3910-RHEUMATIC FEV/HEART INV	48	53.3%	18	20.0%	7	7.8%	18	17.8%	1	1.1%	90	100.0%
3950-DIS AORTIC VALVE	120	35.4%	57	16.8%	92	27.1%	67	19.8%	3	0.9%	339	100.0%
3980-OTHER RHEUMATIC HEART DIS	182	62.1%	36	12.3%	14	4.8%	57	19.5%	4	1.4%	293	100.0%
4010-ESSENTIAL HYPERTENSION	14	31.1%	9	20.0%	9	20.0%	5	11.1%	8	17.8%	45	100.0%
4020-HYPERTEN VASCULAR DIS	33	28.2%	41	35.0%	25	21.4%	15	12.8%	3	2.6%	117	100.0%
4030-HYPERTEN VAS/RENAL DIS	9	26.5%	15	44.1%	7	20.6%	2	5.9%	1	2.9%	34	100.0%
4100-ACUTE MYOCARDIAL INFARC	1	10.0%	5	60.0%	4	40.0%	0	0.0%	0	0.0%	10	100.0%
4130-ANGINA PECTORIS	5	45.5%	2	18.2%	2	18.2%	1	9.1%	1	9.1%	11	100.0%

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

IMPAIRMENT	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
4140-CHRONIC ISCHEMIC HEART DIS	81	41.8%	39	20.1%	38	19.6%	28	14.4%	8	4.1%	194	100.0%
4160-CHRONIC PULMON HEART DIS	66	38.4%	53	30.8%	37	21.5%	14	8.1%	2	1.2%	172	100.0%
4250-CARDIOMYOPATHY	91	34.5%	98	37.1%	41	15.5%	29	11.0%	5	1.9%	264	100.0%
4270-CARDIAC DYSRHYTHMIAS	104	33.3%	112	35.9%	58	17.9%	39	12.5%	1	0.3%	312	100.0%
4280-HEART FAILURE	938	32.4%	691	23.9%	1,193	41.3%	55	1.9%	14	0.6%	2,891	100.0%
4380-LATE EFFECTS OF CVA	514	55.7%	175	19.0%	68	7.4%	148	15.8%	19	2.1%	922	100.0%
4410-AORTIC ANEURYSM	4	18.2%	9	40.9%	4	18.2%	4	18.2%	1	4.5%	22	100.0%
4430-PERIPHERAL VASCULAR DIS	9	26.5%	8	23.5%	4	11.8%	10	29.4%	3	8.8%	34	100.0%
4460-POLYAR NODOSA/ALLIED COND	10	45.5%	6	27.3%	2	9.1%	3	13.6%	1	4.5%	22	100.0%
4480-DISEASES OF CAPILLARIES	12	60.0%	4	20.0%	2	10.0%	2	10.0%	0	0.0%	20	100.0%
4510-PHLEBITIS/THROMBOPHLEBITIS	2	28.6%	1	14.3%	1	14.3%	2	28.6%	1	14.3%	7	100.0%
4540-VARICOSE VEINS/LOW EXTREM	2	20.0%	5	50.0%	0	0.0%	3	30.0%	0	0.0%	10	100.0%
4590-OTHER DIS CIRC SYS	47	26.3%	44	24.6%	51	28.5%	38	20.1%	1	0.8%	179	100.0%
4910-CHRONIC BRONCHITIS	29	41.4%	20	28.6%	13	18.6%	8	11.4%	0	0.0%	70	100.0%
4920-EMPHYSEMA	12	38.7%	14	45.2%	3	9.7%	1	3.2%	1	3.2%	31	100.0%
4930-ASTHMA	7,304	49.7%	3,498	23.8%	1,331	9.1%	2,468	18.8%	104	0.7%	14,705	100.0%
4940-BRONCHIECTASIS	20	26.3%	31	40.8%	17	22.4%	8	10.5%	0	0.0%	78	100.0%
4960-CHRONIC PUL INSUFFIC/COPD	393	51.0%	227	29.5%	94	12.2%	51	6.6%	5	0.6%	770	100.0%
5010-ASBESTOSIS	3	60.0%	0	0.0%	1	20.0%	1	20.0%	0	0.0%	6	100.0%
5050-PNEUMOCONIOSIS	8	30.8%	13	50.0%	3	11.5%	2	7.7%	0	0.0%	26	100.0%
5190-OTHER DIS RESPIRATORY SYS	287	18.6%	554	32.1%	712	41.3%	158	9.0%	18	0.9%	1,725	100.0%
5300-DISEASES OF ESOPHAGUS	10	10.6%	20	21.3%	48	51.1%	15	16.0%	1	1.1%	94	100.0%
5330-PEPTIC ULCER	1	8.3%	4	33.3%	4	33.3%	3	25.0%	0	0.0%	12	100.0%
5350-GASTRITIS/DUODENITIS	6	25.0%	3	15.0%	5	25.0%	8	30.0%	1	5.0%	20	100.0%
5530-HERNIAS	4	9.3%	7	18.3%	31	72.1%	1	2.3%	0	0.0%	43	100.0%
5550-REG ENTERITIS/GRANULO COL.	188	35.0%	179	33.6%	109	20.5%	51	9.6%	7	1.3%	532	100.0%
5560-IDIOPATHIC PROCTOCOLITIS	42	26.9%	56	35.9%	41	26.3%	18	10.3%	1	0.6%	156	100.0%
5690-OTHER DISORDERS GASTRO SYS	104	10.7%	235	24.1%	517	53.0%	110	11.3%	9	0.9%	975	100.0%
5710-CHRON LIVER DIS/CIRRHOSIS	633	55.0%	342	29.7%	145	12.6%	28	2.3%	4	0.3%	1,150	100.0%
5780-GASTRO. HEMMORRHAGE	4	17.4%	8	34.8%	6	28.1%	4	17.4%	1	4.3%	23	100.0%
5810-NEPHROTIC SYNDROME	411	41.8%	330	33.4%	142	14.4%	94	9.5%	11	1.1%	988	100.0%
5850-CHRONIC RENAL FAILURE	1,349	77.1%	246	14.1%	107	6.1%	41	2.3%	6	0.3%	1,749	100.0%
5990-OTHER DIS URINARY TRAC	34	11.3%	62	20.6%	123	40.9%	78	25.9%	4	1.3%	301	100.0%
6080-DIS MALE GENITAL ORGANS	4	22.2%	1	5.6%	8	33.3%	5	27.8%	2	11.1%	18	100.0%
6290-DIS FEMALE GENITAL ORGANS	45	19.7%	24	10.5%	17	7.5%	138	60.5%	4	1.8%	228	100.0%
6940-BULLOUS DERMATOSES	29	21.6%	78	58.2%	13	9.7%	14	10.4%	0	0.0%	134	100.0%
6950-ERYTHEMATOUS CONDITIONS	35	36.1%	41	42.3%	7	7.2%	11	11.3%	3	3.1%	97	100.0%
6960-PSORIASIS/SIMILAR DIS	32	23.7%	63	48.7%	15	11.1%	24	17.8%	1	0.7%	135	100.0%
7050-DISORDERS OF SWEAT GLANDS	7	33.3%	5	23.8%	4	19.0%	5	23.8%	0	0.0%	21	100.0%
7090-OTHER DIS SKIN/SUB TISSUE	45	19.7%	74	32.5%	37	16.2%	72	31.6%	0	0.0%	228	100.0%

Appendix 7-F

SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994

IMPAIRMENT	MEETS LISTING	% MEETS LISTING	EQUALS LISTING	% EQUALS LISTING	FUNCT. EQUALS	% FUNCT. EQUALS	IFA ALLOW	% IFA ALLOW	MISC. *	% MISC.	TOTAL ALLOW	% TOTAL ALLOW
7100-DIFFUSE DIS CON TISSUE	247	42.0%	217	36.9%	42	7.1%	74	12.6%	8	1.4%	588	100.0%
7140-RHEUMATOID ARTHRITIS	831	54.3%	381	24.9%	127	8.3%	173	11.3%	18	1.2%	1,530	100.0%
7150-OSTEOARTHRITIS/ALLIED DIS	218	39.9%	133	24.4%	55	10.1%	122	22.3%	18	3.3%	548	100.0%
7200-ANKYLOSING/INFLAM SPONDYL	14	31.8%	9	20.6%	8	18.2%	12	27.3%	1	2.3%	44	100.0%
7240-BACK DISORDERS	239	50.5%	73	15.4%	48	9.7%	99	20.9%	18	3.4%	473	100.0%
7280-MUSCLE,LIGAMENT,FASCIA DIS	2,056	55.4%	830	22.3%	485	13.1%	321	8.6%	22	0.6%	3,714	100.0%
7300-OSTEOMYELITIS/INFEC BONE	131	41.2%	72	22.6%	42	13.2%	69	21.7%	4	1.3%	318	100.0%
7330-OTHER BONE/CARTILAGE DIS	309	34.7%	172	19.3%	170	19.1%	221	24.8%	19	2.1%	891	100.0%
7370-CURVATURE OF SPINE	984	75.6%	148	11.4%	49	3.6%	113	8.7%	8	0.6%	1,302	100.0%
7400-ANENCEPHALUS/CATASTR ANOM	1,563	45.4%	731	21.2%	1,018	29.5%	120	3.5%	14	0.4%	3,448	100.0%
7410-SPINA BIFIDA	3,841	73.1%	759	14.4%	484	8.8%	175	3.3%	18	0.3%	5,257	100.0%
7460-CONGENITAL HEART ANOMALIES	3,782	49.2%	1,405	18.3%	1,969	25.6%	491	8.4%	38	0.5%	7,685	100.0%
7500-CONGEN ANOM/UP ALIMENTARY	100	13.7%	193	26.6%	374	51.4%	57	7.8%	4	0.5%	728	100.0%
7580-CHROMO ANOM/DOWN SNDRME	10,282	90.6%	812	7.2%	104	0.9%	138	1.2%	20	0.2%	11,354	100.0%
7590-OTH CONGENITAL ANOMALIES	1,533	35.4%	845	19.5%	1,170	27.1%	748	17.2%	31	0.7%	4,325	100.0%
7600-MULTIPLE BODY DYSFUNCTION	3,006	65.8%	828	18.1%	549	12.0%	177	3.8%	11	0.2%	4,569	100.0%
7649-BIRTH WGT BETWN 1000 AND 2000 GRAM	55	8.1%	105	15.5%	501	7.1%	13	1.9%	2	0.3%	676	100.0%
7650-BIRTH WGT UNDER 1200 GRAMS (CH)	364	7.0%	575	11.0%	4,218	80.5%	77	1.5%	4	0.1%	5,236	100.0%
7800-SLEEP-RELATED DISORDER	1	14.3%	3	42.9%	3	42.9%	0	0.0%	0	0.0%	7	100.0%
7830-MALNUTR, MARASMUS/GROW IMP	9,014	30.8%	4,185	14.3%	14,847	50.8%	1,100	3.8%	80	0.3%	29,228	100.0%
7840-LOSS OF VOICE	2,165	18.8%	2,772	24.1%	3,079	28.8%	3,418	29.8%	53	0.5%	11,487	100.0%
8030-SKULL FRAC W/O INTERCRAN INJ	7	30.4%	4	17.4%	4	17.4%	8	34.8%	0	0.0%	23	100.0%
8060-VERTEBRAL FRAC/CORD LESION	700	88.8%	55	7.0%	18	2.3%	11	1.4%	8	0.8%	790	100.0%
8180-UPPER LIMB FRACTURES	44	48.3%	12	12.8%	9	9.5%	28	29.5%	2	2.1%	95	100.0%
8270-LOWER LIMB FRACTURES	125	41.5%	75	24.9%	38	12.8%	55	18.3%	8	2.7%	301	100.0%
8290-OTHER FRACTURES	20	33.3%	11	18.3%	15	25.0%	10	16.7%	4	6.7%	60	100.0%
8390-DISLOCATIONS	42	26.8%	39	24.8%	33	21.0%	40	25.5%	3	1.9%	157	100.0%
8480-SPRAINS & STRAINS	8	29.6%	5	18.5%	4	14.8%	9	33.3%	1	3.7%	27	100.0%
8540-INTERCRANIAL INJURY	479	55.1%	120	13.8%	48	5.3%	218	24.9%	8	0.9%	869	100.0%
8690-INTERNAL INJURY	20	37.0%	11	20.4%	10	18.5%	12	22.2%	1	1.9%	54	100.0%
8790-OTHER OPEN WOUNDS	5	27.8%	2	11.1%	5	27.8%	8	33.3%	0	0.0%	18	100.0%
8840-UPPER LIMB OPEN WOUNDS	74	20.4%	87	26.8%	189	48.7%	21	5.8%	1	0.3%	362	100.0%
8940-LOWER LIMB OPEN WOUNDS	61	18.3%	93	27.8%	155	48.4%	22	6.6%	3	0.9%	334	100.0%
9050-LATE EFF/MUSC CON TIS INJ	345	43.8%	149	18.9%	87	11.0%	190	24.1%	17	2.2%	788	100.0%
9070-LATE EFF/NERV SYS INJURY	930	62.0%	208	13.7%	79	5.3%	270	18.0%	18	1.1%	1,501	100.0%
9480-BURNS	77	18.2%	120	28.4%	98	22.7%	121	28.7%	8	1.9%	422	100.0%
OTHER**	12,480	21.8%	6,213	10.9%	9,789	17.1%	28,211	49.3%	589	1.0%	57,262	100.0%
NATIONAL TOTALS	425,808	52.4%	70,149	8.6%	58,508	7.2%	251,108	30.9%	6,838	0.8%	812,409	100.0%

**SUPPLEMENTAL SECURITY INCOME CHILDHOOD DISABILITY DETERMINATIONS
INITIAL CLAIMS - INITIAL LEVEL ALLOWANCES
PRIMARY IMPAIRMENT BY REGULATION BASIS
FEBRUARY 11, 1991 THROUGH DECEMBER 31, 1994**

Appendix 7-F

SOURCE: SSA-831 FILE - YEARS 1991 - 1994
PREPARED BY: SOCIAL SECURITY ADMINISTRATION
DATE PREPARED: 2/95

NOTES:

- INCLUDES ALLOWANCES BASED ON MEDICAL/VOCATIONAL CRITERIA (E.G., DISABLED CHILDREN AGE 18 AND OVER) AS WELL AS ALLOWANCES WHERE NO VALID BASIS CODE WAS RECORDED.
- CASES WHERE THERE IS NO APPLICABLE SSA IMPAIRMENT CODE OR THE DIAGNOSIS IS UNKNOWN AND CASES WHERE THE FIELD WAS NOT PROPERLY CODED.

SSI Issues Affecting Disabled and Blind Children

by Elizabeth M. Boggs, Ph.D.

prepared for NCCD April/May, 1995;
revised September , 1995

Appendix 8

Potential Improvements in SSI - The Next Round:

Feasible Changes that affect Children

INTRODUCTION:

The purpose of this essay is to discuss the rationale for certain improvements in SSI and for increasing the equity of the federal income maintenance programs for people with disabilities generally, without significantly increasing administrative costs. It elaborates on how specific changes in these directions could apply to children, and details a two dimensional, three level stratification (tiering) of benefits based on differential economic disadvantage to the disabled recipient associated with either (a) his specific functional limitations or (b) geographical differentials in costs of living, or both. Also touched on are the difficulties associated with implementing the requirement that claims representatives "develop" a dollar value for "in-kind support and maintenance" received by a beneficiary that in certain cases, reduces his benefits in an inequitable way.

ADEQUACY OF BENEFITS

The Federal benefit rates for SSI, although indexed to inflation, have never come up to the official national poverty levels and there is question as to whether even those levels are adequate in today's housing market, especially for people with impairments. For the last several years the Federal SSI benefit level for an individual with no other income has remained close to 75% of the federal poverty guidelines, an indicator that does not take into account extraordinary out-of-pocket expenses such as may be associated with disability.

Averages can conceal realities, however. On the one hand people who live in warm climates or rural areas and have mild functional impairments may find the present benefits sufficient if they are frugal and fortunate. On the other hand the inadequacy of benefit levels is especially problematic for those of whatever age who live in high cost-of-living areas and have the highest disability-related living expenses and no other income, earned or unearned.

SSI is based on a uniform flat cash grant for an individual (or couple), adjusted for any countable income from other sources. It is recognized that a federally administered program of this type must balance efficiency of administration against a goal of individual equity. Information affecting the net payment level must be easily quantified and punched into a data bank. In this spirit, there is at present no federal adjustment for regional differences in cost of living or for differences in costs incurred that might be related to the relative severity or nature of the disability within the eligible group. It was anticipated that states would provide "state supplementation" in the form of additional cash and that public or private service agencies would be responsive to this variability. The expectations in this regard have been only partially fulfilled. For example, some states with a high cost of living have low supplementation rates, which are often not indexed. The variations in coverage under state Medicaid programs adds to the perpetuation of inequities in the effective use of SSI for both children and adults.

Circumstances have changed since 1974; piecemeal modifications have been made to the law, the rules, and administrative practices, but a comprehensive review involving members of the public had not been undertaken previous to the establishment of the SSI Modernization Project in 1990. The report of its expert advisers, published two months before the 1992 election, contained more than 50 specific recommendations and was a subject of hearings in the House in September, 1993 and March of 1994. The admittedly high cost of implementing one of the priority recommendations, - to raise the income level up to the official HHS poverty level for all SSI recipients - diverted Congress from considering some of the less costly but desirable changes, including improved work incentives and some modification and simplification of the interpretation given to the "in-kind support and maintenance" (ISM) provision.

IN-KIND SUPPORT AND MAINTENANCE (ISM)

"ISM" refers to the attribution of a value to "in-kind support and maintenance" for an SSI child or adult who is "living in the household of another" and receiving such support. If the recipient is not paying his full per capita share of the household costs, he loses one third of his benefit. In determining the value of the ISM in a particular case for purposes of securing the full benefits, the law requires that the value of in-kind support and maintenance be

Appendix 8

individually calculated for that individual, based on the individual's pro rata share of all household expenses including mortgage payments, property taxes, and utilities. (The "development" of this information in cases where it applies is complex and intrusive and takes a disproportionate amount of administrative time.) If the disabled person does not reimburse the householder for this pro rata share, (which may well be impossible if the share as calculated exceeds the benefit), then the benefit is automatically reduced by one third. Although the federal benefit received is uniform across the country, the pro rata share is specific to person and place; thus this methodology discriminates against categorically eligible individuals (and couples), including children, who live in households (not necessarily of their own choosing) with high living costs per inhabitant, elements of which (such as mortgage payments and taxes) may not even benefit the person who has the disability. This provision clearly discriminates against individuals who live in areas of the country with high heating costs or high real estate taxes.

THE EFFECT OF "ISM" RULES WHEN APPLIED TO CHILDREN

Although minor children living with their parents are subject to "deeming" rather than countable "ISM", more than 8% of child SSI recipients do have an "ISM" reduction (equal to one third of the full benefit) (1994 Green Book, p. 234). Most of these children are living with relatives other than parents. AARP has documented the recent rapid increase in the number of children being raised by grandparents and the difficulties they have in accessing federal benefits for their grandchildren (AARP Public Policy Institute, Publications #9502, 9503, March, 1995).

The modernization "experts" recommended doing away with the ISM entirely. Since then I have suggested a less costly and more targeted change to the ISM rule as a "move in the right direction"; it is italicized in what follows:

A person (child or adult) living in the household of another and receiving in-kind support and maintenance will have a one third reduction in the federal benefit level (for an individual) *unless he/she pays the householder at least two thirds of that benefit or the actual pro rata share, whichever is less. (Such payments should not constitute net taxable income to the householder.)*

INDEXING COLAS REGIONALLY

Other proposals brought up by various SSI Modernization Project "experts" but not carried to a conclusion by the group included two that are also related to the inequity of using one national benefit level for all regions of the country and for all levels of disability that fall within the eligibility parameters, given substantial differences in the cost of living. These differences are most pronounced in rentals and heating costs. (Some states recognize one or more cost of living differentials within a state by supplementing differentially by geocode.) One Modernization expert (economist Timothy Smeeding) produced data showing that in 20 states recipients would have (on average) a deficit against their benefit (consisting of the standard federal benefit plus state supplement plus food stamps) after paying only for a typical "economy" rental, along with food, and that in 17 more states the balance remaining for clothing and all other expenses would be less than \$30 a month (the amount of federally funded PNA in an institution).

Two of the experts with experience in administering public assistance programs (Robert Fulton and John Costa) addressed this issue by proposing that the uniform federal benefit levels for individuals and couples should be broken into three tiers based on regional costs of living. Their suggestion was to show a 10% differential in the federal SSI benefit between each of the three tiers. Tiering by geocode is relatively easy to administer. (Memorandum to Panel Members from Robert Fulton, December 30, 1991).

Recommendation: Federal benefit levels will be tiered (using three levels) based on regional differences in overall cost of living criteria. A high level benefit will be 10% above and the low level 10% below the middle or standard level.

ECONOMIC DISADVANTAGE VS. SUBSTANTIAL GAINFUL ACTIVITY

As a member of the SSI Expert Panel I proposed that, in addition, there be three levels (increments) based on the differences in economic impact of the disability itself. My suggestion was based on using information that is already available or can be readily developed during the SSA disability determination process. It

Appendix 8

emphasizes the concept of "functional limitation" as more important than "ability to engage in substantial gainful activity" as a measure of the economic impact of an individual's disability. SGA may measure loss of potential earnings, but does not measure increased costs of living (or working) associated with various impairments. My analysis follows:

When SSI was implemented in 1974 replacing the myriad state definitions with a uniform federal one, the Social Security Administration had already had 15 years of federal experience with the definition of disability under Title II - and its revisions. These years have been followed by a further 20 years of refinement through regulatory interpretation of "the listings", and updating of the statutory language concerning "physical or mental impairment" and "substantial gainful activity" (SGA). The listings have provided us with a viable tool for an alternative definition using standardized but revisable measures of impairment and (where appropriate) residual functional capacity; at the same time SGA has become less and less useful as actual gross wages have become more and more distorted as measures of productive capacity. The inappropriateness of both the concept of SGA and the use of a monetary value as an index have been increasingly apparent in the last decade as attempts have been made to adjust SGA (expressed as dollars of earnings) in the light of various forms of support or wage subsidy or accommodation for a person with a severe continuing disability who (with accommodation) can nevertheless make a net contribution to the GDP. .

On the other hand the functional measures of mental/physical impairments (medical listings) in adults, although necessarily complex, are based on a relevant body of knowledge that has produced credible indicia of "work disability" derived from the (non-working) individual's observable ability (or lack of it) to function in major life activities. These concepts have also more recently been applied to the disability criteria for children. Although the criteria initially developed in response to *Zebley* appear to have been over generous in some specifics, the concept of functionality remains very viable.

BLINDNESS AS A FUNCTIONAL IMPAIRMENT

The use of clinically assessed functional criteria without reference to SGA has always been the rule for SSI claims of blindness; it dates

back to the origins of aid to the blind (Title X) in 1935. The concept of SGA was not part of the original Title X and continues to be missing from Title XVI; it is also substantially irrelevant under Title II.

A person is eligible for SSI based on blindness if he or she is found to meet the definition of "statutory blindness", specifically defined in Section 1614 (a)(2) of the Act: ("..20/200 or less in the better eye with the use of correcting lenses"). See also section 216(i)(1)). This is a *functional definition*. - Although a medically verifiable condition is present, (any one of the large number that may result in blindness) it is the inability to see, that satisfies the requirement. For SSI the only limit on earnings of a person meeting this test arises when the blind person's *countable* earnings, combined with any other countable income, exceed the income limits set for the program; these limits allow special disregards for work expenses, as well as for part of the earnings themselves. Under Title II a person who is eligible based on statutory blindness and has earned income is technically subject to an earnings limit that substantially exceeds the standard SGA and is equated to the the "retirement tests" applied to non-disabled workers over 65, currently (1995) \$940 per month.

People who have "visual impairments" that do not meet the clinical criteria for "statutory blindness" may qualify as "disabled" if they have a lesser degree of loss but meet the SGA earnings test (See 20CFR, Pt. 404 Subpt. P, Appendix I, Section 2.00). Thus, in effect, we already have within the full range of visual impairment, two "tiers", based on relative severity, with the more severe functional loss giving rise to more favorable conditions of income eligibility for those who may have earnings. Without glossing over the uniqueness of blindness, we can recognize the precedent its treatment sets for recognizing differentials in costs of living along the extended range of impairment that can be found in association with each of most major categories of disabling conditions, physical or mental.

My proposal would build on all these findings and precedents so as to redefine disability (for both SSDI and SSI) in a way that will not significantly change the general level of severity (or rate of allowance) associated with the SSA programs but will permit and encourage more of the younger men and women with continuing severe impairments who want to work to do so without being worse off than when not working. While continuing on the rolls in some

Appendix 8

cases, they will at least draw down reduced benefits. as a result of increased earnings.

SPECIFIC RECOMMENDATIONS LEADING TO TIERING

I propose that SSI rules be modified to recognize that, for most people with significant disabilities, there is an increased cost of living, as well as a limitation on employability; to increase the equity of disability benefits I proposed a simple "tiering" of benefits.

Eliminate references to "substantial gainful activity" in Title II [Section 202(d)] and in Title XVI [Section 1614(a)]; reformulate the criteria for disability in terms of disadvantage in performing or participating in major life activities - of which work is clearly a major one.

This move would make for a more nearly seamless definitional approach to children, youth and adults.

A partial move in this direction has been taken in this direction by making allowances for Impairment Related Work Expenses (IRWE). IRWE could be expanded to allow for "impairment related living expenses" but this kind of detailed accounting is administratively costly and places an inappropriate burden on recipients. It is also true that SSI recipients can now bypass the SGA barrier when they attempt work after becoming eligible, losing benefits gradually as earnings increase, up to a point close to the minimum wage. SSDI beneficiaries, on the other hand, although eligible for IRWE, lose all benefits when they exceed SGA. It is important that the definitions of disability and blindness in both Title II and Title XVI remain substantially equivalent; however, to secure adoption of the concept of *extent of economic disadvantage resulting from impairment* in this single statutory definition of disability and to operationalize it will require legislative ingenuity. (This topic was explored in some detail in my contribution to the Experts' Report.)

QUANTIFYING ECONOMIC DISADVANTAGE

The processes presently in place for determining the extent and functional severity of impairments associated with specified physical or mental conditions or disorders in adults readily lend themselves to identifying also the extent of need for personal or

other ongoing assistance of a non-medical nature. As the children's criteria are modified in response to the excesses associated with Zebley, similar assessment information will emerge.

Following the models used in practice by the US Public Health Service as modified in the current wave of the Health Interview Survey, and using practical information from analysis of home and community based services delivered through the Section 1915 waivers, three levels of impairment-related "economic disadvantage" (IREDA) can be established:

- a) most severe - those requiring ongoing frequent assistance of another person in the activities of daily living and/or in instrumental activities of daily living and/or in personal management of income and resources;*
- b) very severe: - those requiring some (less frequent) personal assistance and/or those who require special transportation, special equipment, devices, vehicles, pharmaceuticals, or adapted housing etc. whose usage involves recurring expenses substantially in excess of those experienced by non disabled people;*
- c) severe - those who meet the standard eligibility criteria, but do not experience extraordinary need for sustained non-medical supports, or extraordinary medical supports not otherwise covered. (Medical supports should be covered separately, preferably by Medicare, but at least by Medicaid).*

In taking this course there is one caveat that must be respected.

"Personal assistance" cannot be limited to the traditional ADLs (eating, bathing, toileting), but must include IADL's and assistance with cognitive tasks (banking, corresponding, budgeting, essential reading, planning for the future) along with activities of advocacy, guidance, social support and such supervision as may be required by some people with cognitive impairments, adaptive behavioral or mental health problems.

Appendix 8

The disability supplement to the 1993-4 waves of the National Health Interview Survey attempts to capture some of these variables in "social competence".

It is recommended that there be established a specified federal supplement (e.g. a percentage of the benefit, whether SSI or SSDI/DAC) associated with each of the two classifications: very severe and most severe; alternatively flat rate subsidies could be established for each level, subject to the (subsequent) regional cost of living adjustments proposed earlier.

The cash supplement would recognize some part of the extra out of pocket costs of living experienced by these individuals (and their families) in the ordinary course of life - e.g. the food for the guide dog, the taxi to the station, the diapers, the higher electric bills, the breakage, the extra transportation and supervision.

Individuals receiving these higher payments based on the functional assessment (and their representative payees) should have discretion to use the funds without detailed accounting.

An example of a paradigm for combining these two dimensions of tiering is illustrated at the end of this paper in a 3 x 3 matrix.

OTHER CONSIDERATIONS

It is recognized that such a standard supplement will not obviate the need of many recipients for additional extraordinary personal, social and medical services, as indicated in the description of the "most severe" and "very severe" categories. State and local service systems are presently responsible for giving SSI recipients access to essential services of these kinds based on individual need and monitored for quality and cost under state and local supervision. Actual availability and access is variable among states.

Payments for these more costly services and hardware by third parties including private sources, would continue to be allowed as non-countable in-kind income, but, to be equitable, access should not depend on the good will of third parties. In stressing the importance of graduated approaches based on degree and kind of functional loss, Batavia and Parker (1995) have proposed a 4 tier system with one tier consisting of "Provision Benefits and Other

Interventions", such as assistive devices and personal assistance, as a benefit integral to SSDI itself., a concept readily applicable to children. (Batavia, A.I. & Parker, S.B. *From disability rolls to payrolls; A proposal for Social Security program reform*. J. Disability Policy Studies 6:1:73-86.)

In view of the discussions about the unmet medical needs of SSI children, it should be noted that the Maternal and Child Health program has traditionally been a resource for specialized equipment and rehabilitation for "children with special needs". At one time, under the Mikva amendment, state MCH agencies were mandated to provide rehabilitation for SSI children, using funding from the Social Security trust funds, paralleling the pattern piloted earlier by the state vocational rehabilitation agencies. This practice was discontinued partly because MCH state administrators did not want to exclude non-SSI eligible children in need of medical care and partly because outcomes were not sufficiently documented. It is understood that further retrenchment is now taking place in all MCH funds for direct care, as well as in Medicaid. Consideration should be given to extending Medicare to disabled children (not limited to SSI children) with a sliding scale of premiums payable by child or parent, or out of the SSI appropriation where applicable.

Unfortunately the block granting of an earlier era deprived disabled children and adults of the priorities for social services under Title XX that they enjoyed from 1976 to 1982. It is important that entitlements to health care not suffer the same fate.

Appendix 8

Tiered Benefit Structure: Option #1

Level of Personal Impairment			
Regional Cost of Living	Low	Medium	High
Low	95 %	110%	135 %
Medium	85 %	100 %	120%
High	75 %	90 %	105 %

Percent of Federal Benefit Rate (FBR) allocated to one child with a disability living with parents.

Tiered Benefit Structure: Option #2

Level of Personal Impairment			
Regional Cost of Living	Low	Medium	High
Low	71%	83%	101%
Medium	64%	75%	90%
High	56%	68%	79%

Percent of Federal Benefit Rate (FBR) allocated to one child with a disability living with parents.

IFA AND CASE SUMMARY FOR
A CHILD FROM BIRTH TO ATTAINMENT OF AGE 1¹

NAME:

SSN:

A. Identify any medically determinable impairment(s):

B. Describe how the impairment(s) affects the child's development and performance of age-appropriate activities in the following domains and behaviors. Summarize the evidence that supports your descriptions of functional limitations. Indicate the level of severity of functional impairment in the developmental domains and behaviors.

1. COGNITIVE DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

¹ The Commission members reviewed individualized functional assessments (IFAs) completed by disability determination services staff for 51 children who were approved for SSI disability benefits based on an IFA. The IFAs were altered to omit the childrens' identities.

Appendix 9

2. COMMUNICATIVE DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

3. MOTOR DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

4. SOCIAL DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

5. RESPONSIVENESS TO STIMULI: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

- C. Check the following factors that are applicable in this case. Then describe how each checked factor affects the child's ability to function. Refer to POMS DI 25220.015 for a detailed explanation. Summarize the evidence that supports your descriptions of the effects of these factors.

☐ CHRONIC ILLNESS	☐ MULTIDISCIPLINARY THERAPY
☐ EFFECTS OF MEDICATION	☐ SCHOOL ATTENDANCE
☐ EFFECTS OF STRUCTURED SETTING	☐ OTHER
☐ ADAPTATIONS	

Appendix 9

- D. **CASE SUMMARY:** Provide a narrative profile of how the child is functioning. Explain your conclusions that the impairment(s) is severe, but is not of listing-level severity. Explain your determination whether the impairment(s) substantially reduces (or is reasonably expected to substantially reduce) the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and is, therefore, of comparable severity to an impairment(s) that would disable an adult.

Medical Consultant's Signature

Date

Medical Consultant's Printed Name

IFA AND CASE SUMMARY FOR A CHILD
AGE 1 TO ATTAINMENT OF AGE 3

NAME:

SSN:

A. Identify any medically determinable impairment(s):

B. Describe how the impairment(s) affects the child's development and performance of age-appropriate activities in the following domains and behaviors. Summarize the evidence that supports your descriptions of functional limitations. Indicate the level of severity of functional impairment in the developmental domains and behaviors.

1. COGNITIVE DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

2. COMMUNICATIVE DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

Appendix 9

3. MOTOR DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

4. SOCIAL DEVELOPMENT: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

5. RESPONSIVENESS TO STIMULI: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

- C. Check the following factors that are applicable in this case. Then describe how each checked factor affects the child's ability to function. Refer to POMS DI 25220.015 for a detailed explanation. Summarize the evidence that supports your descriptions of the effects of these factors.

___ CHRONIC ILLNESS

___ MULTIDISCIPLINARY THERAPY

___ EFFECTS OF MEDICATION

___ SCHOOL ATTENDANCE

___ EFFECTS OF STRUCTURED
SETTING

___ OTHER

___ ADAPTATIONS

- D. CASE SUMMARY: Provide a narrative profile of how the child is functioning. Explain your conclusions that the impairment(s) is severe, but is not of listing-level severity. Explain your determination whether the impairment(s) substantially reduces (or is reasonably expected to substantially reduce) the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and is, therefore, of comparable severity to an impairment(s) that would disable an adult.

Medical Consultant's Signature

Date

Medical Consultant's Printed Name

IFA AND CASE SUMMARY FOR A CHILD
AGE 3 TO ATTAINMENT OF AGE 16

NAME:

SSN:

A. Identify any medically determinable impairment(s):

B. Describe how the impairment(s) affects the child's development and performance of age-appropriate activities in the following domains and behaviors. Summarize the evidence that supports your descriptions of functional limitations. Indicate the level of severity of functional impairment in the developmental domains and behaviors.

1. COGNITIVE DEVELOPMENT/FUNCTION: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

2. COMMUNICATIVE DEVELOPMENT/FUNCTION: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

Appendix 9

3. MOTOR DEVELOPMENT/FUNCTION: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

4. SOCIAL DEVELOPMENT/FUNCTION: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate
☐ Marked ☐ Extreme

5. PERSONAL/BEHAVIORAL DEVELOPMENT/FUNCTION: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate
☐ Moderate ☐ Marked ☐ Extreme

6. CONCENTRATION, PERSISTENCE AND PACE: (CHECK ONE)

☐ No Evidence of Limitation ☐ Less Than Moderate ☐ Moderate

☐ Marked ☐ Extreme

- C. Check the following factors that are applicable in this case. Then describe how each checked factor affects the child's ability to function. Refer to POMS DI 25220.015 for a detailed explanation. Summarize the evidence that supports your descriptions of the effects of these factors.

☐ CHRONIC ILLNESS

☐ MULTIDISCIPLINARY THERAPY

☐ EFFECTS OF MEDICATION

☐ SCHOOL ATTENDANCE

☐ EFFECTS OF STRUCTURED
SETTING

☐ OTHER

☐ ADAPTATIONS

Appendix 9

- D. CASE SUMMARY: Provide a narrative profile of how the child is functioning. Explain your conclusions that the impairment(s) is severe, but is not of listing-level severity. Explain your determination whether the impairment(s) substantially reduces (or is reasonably expected to substantially reduce) the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and is, therefore, of comparable severity to an impairment(s) that would disable an adult.

Medical Consultant's Signature

Date

Medical Consultant's Printed Name

IFA AND CASE SUMMARY FOR A CHILD AGE 16
TO ATTAINMENT OF AGE 18

NAME:

SSN:

A. Identify any medically determinable impairment(s):

B. Describe how the impairment(s) affects the child's performance of age-appropriate activities in the following domains and behaviors. Discuss the evidence that supports the description.

1. COGNITIVE FUNCTIONING:

2. COMMUNICATIVE FUNCTIONING:

3. MOTOR FUNCTIONING:

Appendix 9

4. SOCIAL DEVELOPMENT/FUNCTION:

5. PERSONAL/BEHAVIORAL FUNCTIONING:

6. CONCENTRATION, PERSISTENCE AND PACE:

C. Check the following factors that are applicable in this case. Then evaluate how each checked factor affects the child's ability to function. Refer to POMS DI 25220.015 for a detailed explanation. Summarize the evidence that supports your descriptions of the effects of these factors.

___ CHRONIC ILLNESS

___ MULTIDISCIPLINARY THERAPY

___ EFFECTS OF MEDICATION

___ SCHOOL ATTENDANCE

___ EFFECTS OF STRUCTURED
SETTING

___ OTHER

___ ADAPTATIONS

- D. CASE SUMMARY: Provide a narrative profile of how the adolescent is functioning. Explain your conclusions that the impairment(s) is severe, but is not of listing-level severity. Explain your determination whether the impairment(s) substantially reduces (or is reasonably expected to substantially reduce) the child's ability to function independently, appropriately, and effectively in an age-appropriate manner, and is, therefore, of comparable severity to an impairment(s) that would disable an adult.

Medical Consultant's Signature

Date

Medical Consultant's Printed Name