

recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.¹⁶

Examples of Limitations in the Domain of "Health and Physical Well-Being"

To assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Health and physical well-being," we provide the following examples of limitations that are drawn from our regulations, training, and case reviews. They are not the only limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.¹⁷

In addition, as in the examples of limitations for the other five domains, we consider a child's age¹⁸ in determining whether there is a limitation in functioning in the domain of "Health and physical well-being." 20 CFR 416.926a(1)(4). While it is less likely that age will be a factor in determining whether there is a limitation in this domain, it is still possible, and we must consider the expected level of functioning for a given child's age in determining the severity of a limitation.

- Has generalized symptoms caused by an impairment(s) (for example, tiredness due to depression).
- Has somatic complaints related to an impairment(s) (for example, epilepsy).
- Has chronic medication side effects (for example, dizziness).
- Needs frequent treatment or therapy (for example, multiplesurgeries or chemotherapy).
- Experiences periodic exacerbations (for example, pain crises in sickle cell anemia).
- Needs intensive medical care as a result of being medically fragile.

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09-1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09-2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09-3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09-4p, Title

XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09-5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09-6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09-7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2008-0062; Social Security Ruling, SSR 09-1p.]

Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09-1p. This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about our "whole child" approach for determining whether a child's impairment(s) functionally equals the listings.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Bendann, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 965-9118.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration.

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated:

February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach

Purpose: This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about our "whole child" approach for determining whether a child's impairment(s) functionally equals the listings.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in "marked and severe functional limitations."⁴ 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any "individual" who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term "impairment(s)" in this SSR to refer to an "impairment or a combination of impairments."

⁴ The impairment(s) must also satisfy the duration requirement in section 1641(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

¹⁶ For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09-1p.

¹⁷ There are some rules for determining whether there is a "marked" or an "extreme" limitation in the "Health and physical well-being" domain that are unique to this domain. See 20 CFR 416.926a(e)(2)(iv) and 416.926a(e)(3)(iv).

¹⁸ See 20 CFR 416.924b.

Impairments (the listings),⁵ or *functionally equal* the listings (also referred to as “functional equivalence”). 20 CFR 416.924 and 416.926a.

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁶ 20 CFR 416.926a(a). *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
- (2) Attending and completing tasks,
- (3) Interacting and relating with others,
- (4) Moving about and manipulating objects,
- (5) Caring for yourself, and
- (6) Health and physical well-being.

20 CFR 416.926a(b)(1).⁷

Our rules provide that we start our evaluation of functional equivalence by considering the child’s functioning without considering the domains or individual impairments. They provide that “[w]hen we evaluate your functioning and decide which domains may be affected by your impairment(s), we will look first at your activities and limitations and restrictions.”⁸ 20 CFR 416.926a(c) (emphasis added). Our rules also provide that we:

look at the information we have in your case record about how your functioning is affected *during all of your activities* when we decide whether your impairment or combination of impairments functionally equals the listings. Your activities are *everything you do at home, at school, and in your community*.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

⁶ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

⁷ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

⁸ In the preamble to the final childhood disability regulations we published in 2000, we noted that this approach assumes that at this step in the sequential evaluation process for children we have already established the existence of at least one medically determinable impairment that is “severe.” Therefore, * * * we are looking primarily at the extent of the limitation of the child’s functioning. We look at all of the child’s activities to determine the child’s limitations or restrictions and then decide which domains to use. 65 FR 54747, 54757 (2000).

20 CFR 416.926a(b) (emphasis added).

After we identify which of a child’s activities are limited, we determine which domains are involved in those activities. We then determine whether the child’s impairment(s) could affect those domains and account for the limitations. This is because:

[a]ny given activity may involve the integrated use of many abilities and skills; therefore, any single limitation may be the result of the interactive and cumulative effects of one or more impairments. And any given impairment may have effects in more than one domain; therefore, we will evaluate the limitations from your impairment(s) in any affected domain(s).

20 CFR 416.926a(c). We then rate the severity of the limitations in each affected domain.

This technique for determining functional equivalence accounts for all of the effects of a child’s impairments singly and in combination—the interactive and cumulative effects of the impairments—because it starts with a consideration of actual functioning in all settings. We have long called this technique our “whole child” approach.

Policy Interpretation

I. General

We always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can make a fully favorable determination or decision without having to do so. The functional equivalence rules require us to begin by considering how the child functions every day and in all settings compared to other children the same age who do not have impairments. After we determine how the child functions in all settings, we use the domains to create a picture of how, and the extent to which, the child is limited by identifying the abilities that are used to do each activity, and assigning each activity to any and all of the domains involved in doing it. We then determine whether the child’s medically determinable impairment(s) accounts for the limitations we have identified. Finally, we rate the overall severity of limitation in each domain to determine whether the child is “disabled” as defined in the Act.

More specifically, we consider the following questions.

1. *How does the child function?* “Functioning” refers to a child’s activities; that is, everything a child does throughout the day at home, at school, and in the community, such as getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments. We consider:

- What activities the child is *able* to perform,
 - What activities the child is *not able* to perform,
 - Which of the child’s activities are *limited or restricted*,
 - Where the child has difficulty with activities—at home, in childcare, at school, or in the community,
 - Whether the child has difficulty independently initiating, sustaining, or completing activities,
 - The kind of help, and how much help the child needs to do activities, and how often the child needs it, and
 - Whether the child needs a structured or supportive setting, what type of structure or support the child needs, and how often the child needs it.
- 20 CFR 416.926a(b)(2).

2. *Which domains are involved in performing the activities?* We assign each activity to any and all of the domains involved in performing it. Many activities require more than one of the abilities described by the first five domains and may also be affected by problems that we evaluate in the sixth domain.

3. *Could the child’s medically determinable impairment(s) account for limitations in the child’s activities?* If it could, and there is no evidence to the contrary, we conclude that the impairment(s) causes the activity limitations we have identified in each domain.

4. *To what degree does the impairment(s) limit the child’s ability to function age-appropriately in each domain?* We consider how well the child can initiate, sustain, and complete activities, including the kind, extent, and frequency of help or adaptations the child needs, the effects of structured or supportive settings on the child’s functioning, where the child has difficulties (at home, at school, and in the community), and all other factors that are relevant to the determination of the degree of limitation. 20 CFR 416.924a.

This technique of looking first at the child’s actual functioning in all activities and settings and considering all domains that are involved in doing those activities, accounts for the interactive and cumulative effects of the child’s impairment(s), including any impairments that are not “severe.” This is because limitations in a child’s activities will generally be the manifestation of any difficulties that result from the impairments both individually and in combination.⁹

⁹ As noted in question no. 3 above, we would not make this assumption if there is evidence indicating that a child’s limitations are not attributable to a

In sections II, III, and IV, we provide more detail about the technique for determining functional equivalence. However, we do not require our adjudicators to discuss all of the considerations in the sections below in their determinations and decisions, only to provide sufficient detail so that any subsequent reviewers can understand how they made their findings.

II. Determining Which Domains Are Involved in Doing Activities

A. General

The “whole child” approach recognizes that many activities require the use of more than one of the abilities described in the first five domains, and that they may also be affected by a problem that we consider in the sixth domain. A single impairment, as well as a combination of impairments, may result in limitations that require evaluation in more than one domain.¹⁰ Conversely, a combination of impairments, as well as a single impairment, may result in limitations that we rate in only one domain.

Therefore, it is incorrect to assume that the effects of a particular medical impairment must be rated in only one domain or that a combination of impairments must always be rated in several. Rather, adjudicators must consider the particular effects of a child’s impairment(s) on the child’s activities in any and all of the domains that the child uses to do those activities, based on the evidence in the case record.¹¹

In the sections that follow, we provide examples to illustrate how we apply these principles. These examples do not indicate whether a child is disabled, only how we assign limitations in a child’s activities to a domain or domains. The rating of severity—determining whether the child is disabled—comes later. See sections III and IV below.

medically determinable impairment(s). However, in most cases, limitations that are of listing-level severity will be associated with underlying physical or mental impairments.

¹⁰ Rating the limitations caused by a child’s impairment(s) in each and every domain that is affected is *not* “double-weighting” of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child’s impairment(s) in all domains involved in the child’s limited activities.

¹¹ By the time we reach the functional equivalence step, we will have already determined that the child has at least one medically determinable impairment that is “severe”; that is, it that causes more than minimal functional limitations. 20 CFR 416.924. Therefore, the child must have a limitation in at least one domain.

B. Examples of Activities That Typically Require Two or More Abilities

1. *Tying shoes.* Tying shoes typically requires abilities in at least four domains:

- Learning and remembering the sequence for tying (Acquiring and using information),
- Focusing on the task (Attending and completing tasks),
- Using the fingers and hands to do the task (Moving about and manipulating objects), and
- Taking responsibility for dressing and appearance (Caring for yourself).

Therefore, depending on the nature and effects of the impairment(s), a child who has difficulty tying his shoes may have limitations in one, two, three, or even all of these domains. For example, if a child has a deformity of the hands and fingers that affects only manipulation, the only domain that might be affected is “Moving about and manipulating objects.” However, if the child has pain or other symptoms, there might also be a problem in concentration, which we would also evaluate in the domain of “Attending and completing tasks.” There might also be limitations in other domains.¹²

2. *Riding a public bus.* Taking a public bus independently typically requires the abilities in the first five domains:

- Knowing how, where, and when to catch the bus, which bus to ride, the amount of the fare and how to pay it, and how and where to get off, as well as properly accomplishing these tasks (Acquiring and using information, Attending and completing tasks).
- Relating appropriately to the driver and other passengers (Interacting and relating with others),
- Being physically able to get on and off the bus (Moving about and manipulating objects), and
- Following safety rules (Caring for yourself).

Again, depending on the nature and particular effects of the impairment(s), a child who has difficulty riding a public bus may have limitations in any one, two, several, or even all of these domains.

C. Example of a Child With a Single Impairment That Is Rated in More Than One Domain

A boy in elementary school with attention-deficit/hyperactivity disorder

¹² Children who have mental disorders will often have limitations that are rated in more than one domain, but as we explain in the domain-specific SSRs referenced at the end of this SSR, physical impairments can also have effects that must be assigned to more than one domain.

(AD/HD) has trouble with all of the following activities.

1. *Reading class assignments.* The child repeatedly misreads words by impulsively guessing what they are based on the first letters or the shapes of the words, and he is not keeping up with the rest of his class. His ability to learn and think about information in school is at least partly dependent on how well he can read. These difficulties indicate a limitation in the domain of “Acquiring and using information.”

2. *Following classroom instructions.* The child generally carries out only the first part of three-part instructions. Being unable to sustain focus, he quickly goes on to unrelated activities. He also makes mistakes in carrying out the instructions on which he does try to focus. He needs controlled, directed attention to carry out instructions correctly. These difficulties indicate a limitation in the domain of “Attending and completing tasks.”

3. *Playing with others.* The child will typically approach a group of children, interrupt whoever is talking, and begin telling his own story, leading to conflicts with the other children. To successfully interact and relate with peers, the child must understand the social situation and use appropriate behaviors to approach other children. These difficulties indicate a limitation in the domain of “Interacting and relating with others.”

4. *Avoiding danger.* The child often impulsively dashes out into the street without looking for cars and considering his safety. Being responsible for his own safety requires the child to stop moving and to be cautious before stepping into the street. These difficulties in self-related activities indicate a limitation in the domain of “Caring for yourself.”

Therefore, even though attentional difficulties and hyperactivity are hallmarks of AD/HD, in this case it would be incorrect to assume that this child’s AD/HD causes limitations only in the domain of “Attending and completing tasks.” This child’s activities demonstrate that his single impairment causes limitations that we must rate in four domains.

D. Example of a Child With a Combination of Impairments That Is Rated in Only One Domain

A girl in middle school has a mild hearing disorder that affects both her hearing and speech. She also has a repaired complete cleft lip and palate that affects her speech as well as her appearance. She has difficulty hearing other children, especially on the playground during games, and they have difficulty understanding what she

says. The other children do not approach her, and they also make fun of her because of her appearance and speech difficulties. Consequently, she has difficulty forming friendships with her classmates. She tends to stay to herself during recess and lunchtime and plays alone when at home.¹³

However, she does not have any difficulty learning. She completes all her schoolwork and chores on time, appropriately, and without unusual assistance, is well-behaved and otherwise cares for herself age-appropriately. She also has no motor difficulties.

In this example, the evidence shows that the child has only social limitations at school and in her neighborhood, and that the limitations in her activities are the result of her difficulty communicating effectively with other children because of her hearing and speech problems and appearance. Therefore, the combination of this child's two impairments causes limitations only in the domain of "Interacting and relating with others."

It is unnecessary to evaluate the effects of each of the child's impairments separately and then to determine their combined effects. Since we start by evaluating her functioning (in this case, her social limitations), the limitations in interacting and relating with others established by the evidence in the case record reflect the combined effects of her impairments.

E. Example of a Child With a Combination of Impairments That Is Rated in More Than One Domain

An adolescent has a diagnosis of borderline intellectual functioning (BIF) and has been a "slow learner" throughout school. She also has recently been diagnosed with depression. She has received special education services throughout her school years and is now in the 11th grade. She has attended special classes for all of her academic subjects, but has been mainstreamed for some elective courses and extracurricular activities. Her teacher reports that she performed satisfactorily in most of her classes in previous years, but for the past two semesters has become inattentive in class, has failed three academic subjects because of inattention and failure to complete her assignments, and has frequently refused to go to school. Her mother reports that at home the child cries a lot, sleeps as

long as 12 hours every night, eats irregularly, complains of headaches, and is irritable, uncooperative, and angry more often than not. Despite many attempts, the parent has been unable to engage her daughter in talking about what is wrong and how she might help.

The student's difficulty with activities at school and at home involves three, and possibly four, domains:

1. Her many years of placement in special education classes for all academic work indicate a limitation that we would rate in the domain of "Acquiring and using information."

2. Her inattention in class and current failure in three academic subjects as a consequence indicate that there is also a limitation in the domain of "Attending and completing tasks."

3. Her mother's description of some of the child's difficulties at home (for example, crying, oversleeping, physical complaints, and irritability) and the child's avoidance of dealing with them indicate a limitation in the domain of "Caring for yourself."

4. In addition, if her refusal to talk with her mother and her anger and uncooperativeness exceed what would be expected of adolescents of the same age who do not have any impairments, this would indicate a limitation in the domain of "Interacting and relating with others."

III. Rating Severity

A. General

Once we have determined which of a child's activities are limited, which domain or domains are involved, and that the limitations are the result of a medically determinable impairment(s), we rate the severity of the limitations and determine whether the impairment(s) functionally equals the listings. We consider all relevant evidence in the case record, including objective medical and other evidence, and all of the relevant factors discussed in 20 CFR 416.924a.¹⁴

It is important to determine the extent to which an impairment(s) compromises a child's ability to independently initiate, sustain, and complete activities. To do so, we consider the kinds of help or support the child needs in order to function. See 20 CFR 416.924a(b). In general, if a child needs a person, medication, treatment, device, or structured, supportive setting to make his functioning possible or to improve

the functioning, the child will not be as independent as same-age peers who do not have impairments. Such a child will have a limitation, even if he is functioning well with the help or support.

The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independent the child is in functioning, and the more severe we will find the limitation to be. For example:

- A 10-year-old child who is dressed appropriately may appear not to be limited in this activity. However, if the evidence in the case record shows that the child needs significant help from her parents with the basics of dressing every day (for example, putting on and buttoning shirts), the child will have a limitation of that activity.¹⁵

- A 14-year-old child who has a serious emotional disturbance may be given "wrap-around services" that include the services of an adult who supervises the child at school. With these services, the child attends school, participates in activities with other children, and does not take any actions that endanger himself or others. However, the degree of "extra help" ¹⁶ the child needs to function demonstrates a limitation in at least the domains of "Interacting and relating with others" and "Caring for yourself."

B. Rating the Severity of Limitations in the Domains

When we determine the degree to which the child's impairment(s) limits each affected domain, we use the definitions of "marked" or "extreme" in our regulations. See 20 CFR 416.926a(e). The following discussion provides further guidance about how to apply those definitions.

To determine whether there is a "marked" or an "extreme" limitation in a domain, we use a picture constructed of the child's functioning in each domain. This last step in the "whole child" approach summarizes everything we know about a child's limited activities. The rating of limitation in a domain is then based on the answers to these questions:

¹⁵ The domain or domains in which we would rate the limitation would depend on the reason(s) that the child needs the help. For example, the child may have motor difficulties (Moving about and manipulating objects), difficulties learning or remembering how to dress appropriately (Acquiring and using information), difficulties with attention or impulsivity (Attending and completing tasks), or a combination of some or all of these problems. There may be limitations we would evaluate in other domains as well.

¹⁶ See 20 CFR 416.924a(b)(5).

¹³ Even though this child's underlying ability to socialize may not be affected, there is a limitation in her ability to interact and relate with other children because of indirect effects of her impairments that limit her opportunity to use the ability.

¹⁴ As provided in 20 CFR 416.924a(b), we consider these factors whenever we evaluate functioning at any step of the sequential evaluation process for children. We also use these factors to determine whether a child has a limitation, not just the severity of the limitations.

1. How many of the child's activities in the domain are limited (for example, one, few, several, many, or all)?

2. How important are the limited activities to the child's age-appropriate functioning (for example, basic, marginally important, or essential)?

3. How frequently do the activities occur and how frequently are they limited (for example, daily, once a week, or only occasionally)?

4. Where do the limitations occur (for example, only at home or in all settings)?

5. What factors are involved in the limited activities (for example, does the child receive support from a person, medication, treatment, device, or structured/supportive setting)?

There is no set formula for applying these considerations in each case. A child's day-to-day functioning may be seriously or very seriously limited whether an impairment(s) limits only one activity or whether it limits several. See 20 CFR 416.926a(e)(2) and (e)(3). Also, we may find that a child has a "marked" or "extreme" limitation of a domain even though the child does not have serious or very serious limitations every day. As in any case, we must consider the effects of the impairment(s) longitudinally (that is, over time) when we evaluate the severity of the child's limitations.¹⁷ The judgment about whether there is a "marked" or "extreme" limitation of a domain depends on the importance and frequency of the limited activities and the relative weight of the other considerations described above.

Adjudicators must also be alert to the possibility that limitation of several seemingly minor activities may point to a larger problem that requires further evaluation. For example, a young child may have serious difficulty with

common childhood activities such as scribbling, using scissors, or copying shapes, which in themselves may not appear to be important to age-appropriate functioning. It would be unlikely, however, that a young child would have *serious* difficulty with those common activities but have no trouble with other activities, such as buttoning a shirt or printing letters, that also involve fine motor or perceptual-motor ability. Such additional difficulties would indicate that the child has more significant problems with age-appropriate functioning than just scribbling, using scissors, or copying shapes alone might suggest.

Finally, the rating of limitation of a domain is not an "average" of what activities the child can and cannot do. When evaluating whether a child's functioning is age-appropriate, adjudicators must consider evidence about all of the child's activities. We do not "average" all of the findings in the evidence about a child's activities to come up with a rating for the domain as a whole. The fact that a child can do a particular activity or set of activities relatively well does not negate the difficulties the child has in doing other activities.

IV. Example of a Functional Equivalence Analysis

In this section, we provide an example of how we would consider a child's activities at the functional equivalence step. In this example, we provide only partial evidence to illustrate how we consider activities and sort them into the domains. We do not rate the severity of the limitations because we are not providing complete evidence and because rating severity based on a specific set of case facts would not be useful in other cases.

Example: A parent files a claim on behalf of her 8-year-old son, alleging that anxiety keeps him from living normally, going to school regularly, and playing with other children. The evidence establishes that the child has a generalized anxiety disorder (GAD) that is "severe" but that does not meet or medically equal listing 112.06.

A. How does the child function?

The child says that he cannot sleep because he is afraid of the dark and the noises he hears outside, and that he needs to be awake and keep his eyes

open as long as possible in case anything happens. His mother reports that he refuses to go to bed, must be coaxed into his room, frequently will not stay there, and gets up and watches television until he falls asleep in front of it. He does not sleep well at night and in the daytime is often irritable. Sometimes, he is combative. He cries when he has to leave for school, and his mother must sometimes ride with him on the school bus. His teacher reports a reduction in his energy and attention in school, that he has trouble focusing in class and does little work at school or at home, and that he may not be promoted at the end of the year because he has fallen behind in his learning. She also reports that he sometimes refuses to leave the classroom for recess or activities anywhere else in the school building or playground, and that an aide must stay with him when he does. She says that the child seems suspicious of other children in his class because he frequently reports things they do and say that worry and frighten him.

The child is seen regularly by a clinical psychologist. Results of formal evaluation, including an anxiety scale and a depression inventory, contribute to a profile of GAD. His pediatrician prescribed two kinds of medications, but both had unacceptable side effects, so the child does not take them. He is in play therapy.

B. Which domains are involved in the child's limited activities?

The following chart¹⁸ provides a picture of the child's functioning, including information about several factors that are relevant to determining the severity of his limitations; for example, help from a parent and school aide, medications, and play therapy. As shown in the chart, the descriptions from the evidence about how the child functions must be specific, not general. For example, "the child is anxious" is a general conclusion, while the notes in the chart below state specifically what the child does and how he does it, based on his own words and the observations of the medical sources and adults who know him and spend the most time with him.

¹⁸This chart is for illustration only. We do not require our adjudicators to develop or use such a chart.

¹⁷For example, in 20 CFR 416.924a(b)(8), we provide: "If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), we will consider the frequency and severity of your episodes of exacerbation as factors that may be limiting your functioning. Your level of functioning may vary considerably over time. Proper evaluation of your ability to function in any domain requires us to take into account any variations in your level of functioning to determine the impact of your chronic illness on your ability to function over time." When we published this rule in 2000, we explained that, while we adopted the language from section 12.00D of the adult mental disorders listings, "[t]his principle is equally applicable to children and adults, and to both physical and mental impairments." See 65 FR at 54754.

Acquiring & using information	Attending & completing tasks	Interacting & relating with others	Moving about & manipulating objects	Caring for yourself	Health & physical well-being
Does little work in class or at home and has fallen behind; may not be promoted to next grade in school.	Attention at school is reduced; has trouble focusing in class; does little work in class or at home.	Despite orders from mother, refuses to go to bed; mother must coax him into bedroom; will not stay in bed; gets up and watches TV until falls asleep. May be combative at home. Sometimes refuses to leave classroom for recess and activities elsewhere; in that case, an aide must stay with him. Frequently reports other children's actions and conversations; seems suspicious of them.	(No limitations.)	Difficulty sleeping; afraid of dark and outside noises; needs to stay awake and keep eyes open (be vigilant). Parent must coax him into bedroom. Will not stay in bed; watches TV until falls asleep. Is irritable because of lack of sleep. Cries when has to leave for school; mother may have to ride bus with him to school. Anxiety scale shows GAD. Child is in play therapy.	Pediatrician has tried short-term Valium; child complained of stomach cramps and headache; tried short-term Ativan; side effects were dizziness and daytime sleepiness.

C. Could the child's medically determinable impairment(s) limit any of his activities?

In the example described above, the medically determinable impairment of GAD clearly accounts for the child's problems, and there is no evidence to the contrary.¹⁹ Therefore, it is appropriate to conclude that the child's GAD results in limitations that are evaluated in five of the six domains, as indicated in the chart above.

V. Responsibility for Determining Functional Equivalence

The responsibility for making functional equivalence determinations depends on the level of the administrative review process.

- For initial and reconsideration determinations, the State agency medical or psychological consultant has the overall responsibility for determining functional equivalence.

- When an SSI recipient has requested a hearing before a disability hearing officer at the reconsideration

¹⁹ With other facts, additional development might be needed. For example, if the evidence in this case showed that the child performed poorly in sports (which we mention as a typical activity of children without impairments), we would note that GAD would not be expected to affect the child's physical ability to move about and manipulate objects. Therefore, poor performance in sports in a child with GAD might be attributable to something other than the mental disorder. There may not be a medical reason at all: The child might do poorly because he does not like to play any sport, is not good at sports, or is not interested in them. On the other hand, there might be another impairment not yet documented by evidence from an acceptable medical source that would limit motor functioning and interfere with the child's day-to-day activities; in such instances, additional development might be needed to complete the evaluation of the child's functioning.

level, the disability hearing officer determines functional equivalence.

- For cases at the Administrative Law Judge (ALJ) and Appeals Council (AC) levels (when the AC makes a decision), the ALJ or AC determines functional equivalence. 20 CFR 416.926a(n).

While SSR 96-6p²⁰ requires that an ALJ or the AC must obtain an updated medical expert opinion before making a decision of disability based on *medical* equivalence, there is no such requirement for decisions of disability based on *functional* equivalence. Therefore, ALJs and the AC (when the AC makes a decision) are not required to obtain updated medical expert opinions when they determine that a child's impairment(s) functionally equals the listings.²¹

Effective date: This SSR is effective on March 19, 2009.

Cross-References: SSR 09-2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-

²⁰ See SSR 96-6p, Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence, 61 FR 34466 (1996), available at: http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR96-06-di-01.html.

²¹ For cases pending at the ALJ and AC levels from States in the Ninth Circuit (Alaska, Arizona, California, Guam, Hawaii, Idaho, Montana, Nevada, Northern Mariana Islands, Oregon, and Washington) at the time of the ALJ or AC decision, see Acquiescence Ruling 04-1(9), *Howard on behalf of Wolff v. Barnhart*, 341 F.3d 1006 (9th Cir. 2003)—Applicability of the Statutory Requirement for Pediatrician Review in Childhood Disability Cases to the Hearings and Appeals Levels of the Administrative Review Process—Title XVI of the Social Security Act, 69 FR 22578 (2004), available at: http://www.socialsecurity.gov/OP_Home/rulings/ar/09/AR2004-01-ar-09.html.

Related Limitations; SSR 09-3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Acquiring and Using Information”; SSR 09-4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Attending and Completing Tasks”; SSR 09-5p, Title XVI: Determining Childhood Disability—“Interacting and Relating with Others”; SSR 09-6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Moving About and Manipulating Objects”; SSR 09-7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Caring for Yourself”; SSR 09-8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being”; SSR 98-1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; SSR 96-6p, Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9-3375 Filed 2-13-09; 8:45 am]

BILLING CODE 4191-02-P

Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (<http://www.sec.gov/rules/sro.shtml>); or
- Send an e-mail to rule-comments@sec.gov. Please include File Number SR-NASDAQ-2009-004 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Commission, 100 F Street, NE., Washington, DC 20549-1090. All submissions should refer to File Number SR-NASDAQ-2009-004. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (<http://www.sec.gov/rules/sro.shtml>). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly.

All submissions should refer to File Number SR-NASDAQ-2009-004 and should be submitted on or before March 11, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.¹³

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9-3484 Filed 2-17-09; 8:45 am]

BILLING CODE 8011-01-P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 11651]

Oregon Disaster # OR-00027 Declaration of Economic Injury

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Economic Injury Disaster Loan (EIDL) declaration for the State of Oregon, dated 02/11/2009.

Incident: Severe Winter Storm System.

Incident Period: 12/14/2008 through 01/04/2009.

DATES: *Effective Date:* 02/11/2009.

EIDL Loan Application Deadline Date: 11/12/2009.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's EIDL declaration, applications for economic injury disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties:

Columbia, Hood River, Multnomah, Washington.

Contiguous Counties:

Oregon: Clackamas, Clatsop, Tillamook, Wasco, Yamhill.

Washington: Clark, Cowlitz, Klickitat, Skamania, Wahkiakum.

The Interest Rate is: 4.000.

The number assigned to this disaster for economic injury is 116510.

The States which received an EIDL Declaration # are Oregon, Washington.

(Catalog of Federal Domestic Assistance Number 59002)

Darryl K. Hairston,

Acting Administrator.

[FR Doc. E9-3404 Filed 2-17-09; 8:45 am]

BILLING CODE 8025-01-P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2008-0062]

Social Security Ruling, SSR 09-2p.; Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09-2p. This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about documenting and evaluating evidence of a child's impairment-related limitations and related issues.

DATES: *Effective Date:* March 20, 2009

FOR FURTHER INFORMATION CONTACT: Robin Doyle, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 966-2771.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

¹³ 17 CFR 200.30-3(a)(12).

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations

Purpose: This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about documenting and evaluating evidence of a child's impairment-related limitations and related issues.

Citations (Authority): Sections 1614(a)(3) and 1614(a)(4) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.912, 416.913, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in "marked and severe functional limitations."⁴ 20 CFR 416.906. This means that the impairment(s) must meet or medically equal a listing in the Listing of Impairments (the listings),⁵ or functionally equal the listings (also referred to as "functional equivalence"). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the "whole child" when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable

determination or decision.⁶ We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). Activities are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child's impairment(s) by rating the degree to which the impairment(s) limits functioning in six "domains." Domains are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
 - (2) Attending and completing tasks,
 - (3) Interacting and relating with others,
 - (4) Moving about and manipulating objects,
 - (5) Caring for yourself, and
 - (6) Health and physical well-being.
- 20 CFR 416.926a(b)(1).⁸

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain.⁹ 20 CFR 416.926a(a).

This SSR explains the evidence we need to document a child's impairment-related limitations, the sources of evidence we commonly see in

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the severity of a child's limitations in functioning, as described in the following paragraphs, we must consider any variations in the child's level of functioning to determine the impact of the chronic illness on the child's ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child's limitations, see SSR 09–1p.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being."

⁹ See 20 CFR 416.926a(e) for definitions of the terms "marked" and "extreme."

childhood disability cases, how we consider the evidence we receive from early intervention and school programs (including special education), how we address inconsistencies in the evidence, and other issues related to the development of evidence about functioning.¹⁰

Policy Interpretation

I. General

We use evidence of a child's functioning to determine whether the child's medically determinable impairment(s):

- Is "severe"—that is, causes more than minimal functional limitations (20 CFR 416.924(c));
- Meets or medically equals a listed impairment when the listing criteria include functioning (20 CFR 416.924a(b)(1)); and
- Functionally equals the listings (20 CFR 416.926a).

When we consider functioning in children, we evaluate how the impairment(s) affects the ability to function age-appropriately. A child functions age-appropriately when initiating, sustaining, and completing age-appropriate activities. "Functioning" includes everything a child does throughout a day at home, at school, and in the community. Examples include, getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments.

As we explain in Section III below, evidence of a child's functioning can come from a wide variety of sources. We will consider all of the relevant evidence we receive about a child's functioning to help us understand how the impairment(s) affects the child's day-to-day activities.

II. What Evidence Do We Need About a Child's Impairment-Related Limitations?

We need evidence that is sufficient to evaluate a child's limitations on a longitudinal basis; that is, over time. This evidence will help us answer the following questions about whether the child's impairment(s) affects day-to-day functioning and whether the child's activities are typical of other children of the same age who do not have impairments. Accordingly, we need evidence to help us determine the following:

- What activities is the child able to perform?
- What activities is the child not able to perform?

¹⁰ For more information about the domains, see the cross-references at the end of this SSR.

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any "individual" who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term "impairment(s)" in this SSR to refer to an "impairment or a combination of impairments."

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause "marked and severe functional limitations." 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

- Which of the child's activities are limited or restricted compared to other children of the same age who do not have impairments?
- Where does the child have difficulty with activities—at home, in childcare, at school, or in the community?
- Does the child have difficulty independently initiating, sustaining, or completing activities?
- What kind and how much help does the child need to do activities, and how often does the child need it?
- Does the child need a structured or supportive setting, what type of structure or support does the child need, and how often does the child need it?

We do not require our adjudicators to provide formal answers to these specific questions in the determination or decision. However, the evidence should create a clear picture of the child's functioning in the context of the six functional equivalence domains so that we can determine the severity of limitation in each domain. The critical element in evaluating the severity of a child's limitations is how appropriately, effectively, and independently the child performs age-appropriate activities.

Also, a child who is having significant but unexplained problems may have an impairment(s) that has not yet been diagnosed, or may have a diagnosed impairment(s) for which we lack evidence. For example, children who are many grades behind in school often have a medically determinable impairment(s). In many cases, the school will have evaluated the child, and the school records will provide information about whether there is a medically determinable impairment(s).¹¹ It may be necessary to further develop information from the child's medical source(s) or purchase a consultative examination (CE). Adjudicators should pursue indications that an impairment(s) may be present if that fact may be material to the determination or decision.

III. Sources of Evidence About a Child's Impairment-Related Limitations

Once we have evidence from an acceptable medical source¹² that

¹¹ This will be especially true in cases in which the child is behind in school because of mental retardation, borderline intellectual functioning, or a learning disability, which can be established by evidence from a school psychologist, or because of a language disorder, which can be established by a qualified speech-language pathologist. See 20 CFR 416.913(a). However, school records may include evidence from other kinds of acceptable medical sources establishing the existence of a medically determinable impairment.

¹² The term "acceptable medical source" is defined in 20 CFR 416.902 as "one of the sources

establishes the existence of at least one medically determinable impairment, we consider all relevant evidence in the case record to determine whether a child is disabled. This evidence may come from acceptable medical sources and from a wide variety of "other sources."¹³

Medical Sources: Acceptable medical sources can provide information about how an impairment(s) affects a child's everyday activities. For example, a pediatrician might discuss the impact of asthma on a child's participation in physical activities, or a speech-language pathologist might discuss how a language disorder contributes to limited attention and problems in school.

We cannot use evidence from other medical sources who are not "acceptable medical sources" to establish that a child has a medically determinable impairment. However, we can use evidence from these sources, such as nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, occupational therapists (OTs), physical therapists (PTs), and psychiatric social workers (PSWs), to determine the severity of the impairment(s) and how it affects the child's ability to function compared to children of the same age who do not have impairments. For example:

- A PSW might comment on the child's ability to handle stressful situations.
- An OT or PT may evaluate the impact of a musculoskeletal disorder on the child's activities and comment on muscle tone and strength and how it affects the child's ability to walk with a brace.
- An OT might comment on the child's ability to use motor skills to get dressed without assistance.

Non-Medical Sources: Evidence from other sources who are not medical sources and who know and have contact with the child can also be very important to our understanding of the severity of a child's impairment(s) and how it affects day-to-day functioning. These sources include parents and

described in 416.913(a) who provides evidence about your impairments."

¹³ We explain what the term "other sources" means in 20 CFR 416.913(d). For more information about how we consider opinion evidence from "other sources," including opinions about functional limitations, see SSR 06-03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 FR 45593 (2006), available at: http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR2006-03-di-01.html. For information about how we consider opinion evidence from acceptable medical sources, see generally 20 CFR 416.927.

caregivers, educational personnel (for example, teachers, early intervention team members, counselors, developmental center workers, and daycare center workers), public and private social welfare agency personnel, and others (for example, siblings, friends, neighbors, and clergy).

Therefore, we will consider evidence from such non-medical sources when we determine the severity of the child's impairment(s) and how the child typically functions compared to children of the same age who do not have impairments.

IV. Early Intervention and School Programs¹⁴

In most cases, early intervention (EI) and school programs are significant sources of evidence about a child's impairment-related limitations. Children from birth to the attainment of age 3 may receive EI services if they are experiencing delays in one or more developmental areas or if they have a diagnosed physical or mental condition that is likely to result in such delays.¹⁵ Children from ages 3 through 5 may attend preschool or other daycare programs. Children age 6 and older usually attend school and may receive special education and related services¹⁶ if they require specially designed instruction because of their unique needs related to a physical or mental impairment(s).

We require adjudicators to try to get EI and school records whenever they are needed to make a determination or decision regarding a child's disability. We do not require information from EI or school personnel in every case because sometimes we can decide that a child is disabled without it, such as when the child's impairment(s) meets the requirements of a listing. We may also have to make a determination or decision without EI or school evidence when we are unable to obtain it.

¹⁴ School programs also include preschool programs, such as Early Head Start (for children birth to age 3) and Head Start (ages 3 through 5).

¹⁵ EI services may include occupational therapy, physical therapy, speech therapy, psychological services, audiology, health services, nutrition services, nursing services, and assistive technology devices. The developmental areas are: Cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development.

¹⁶ "Related services" includes transportation and such developmental, corrective, and other supportive services (such as physical and occupational therapy) as are required to assist a child with a disability to benefit from special education. A child who does not qualify for special education may qualify for related services under section 504 of the Rehabilitation Act of 1973 to ensure a free, appropriate public education. See section IV.C., below.

A. Comprehensive Evaluations in EI or School Programs

We will consider the results of comprehensive evaluations we receive. Children receive comprehensive evaluations when they are candidates for EI or special education and related services and periodically after that when they receive these services. These evaluations are usually conducted by a team of qualified personnel¹⁷ who can assess a child in all areas of suspected delay or educational need.

As part of a comprehensive evaluation, the EI or school program will use a variety of assessment procedures and tools to identify a child's unique strengths and needs, as well as all of the services appropriate to address those needs. For younger children, the primary focus of the evaluation is their level of functioning in terms of developmental milestones. For school-age children, the primary focus is their level of academic skills and related developmental needs.

The evaluation generally includes:

- Observations of the child in a learning environment or a natural setting, such as in the home;
- Alternative and informal assessments, such as play-based assessment and review of completed classroom assignments;
- Interviews with parents, teachers, or other appropriate people, including child behavior checklists; and
- Standardized tests, such as a formal development test for a toddler or a formal intelligence or language test for an older child.

When we request information from EI programs or schools, we will ask for the most recent comprehensive evaluation and test results, as well as other evidence that supports the analysis of the child's development or academic skills and related developmental needs. Some children may have received a comprehensive evaluation, but may not be receiving EI or special education services. Therefore, we will request this information even if a child is not receiving services.

B. Individualized Family Service Plans and Individualized Education Programs

The agency providing EI services or special education and related services will develop a written plan documenting the child's eligibility for services, the therapeutic or educational

goals, the services the agency will provide, and the setting(s) where the agency will provide these services. Infants and toddlers should have an Individualized Family Service Plan (IFSP). Preschool and school-age children should have an Individualized Education Program (IEP), including an IEP transition plan for children beginning at age 14.

Both IFSPs and IEPs are important sources of specific information about a child's abilities and impairment-related limitations, and provide valuable information about the various kinds and levels of support a child receives. For example, an IEP will describe:

- Supplementary aids and services, such as speech-language pathology services, counseling, transportation, and orientation and mobility services;
- Modifications to the academic program made to accommodate the child's impairment(s), such as reading instruction in a resource room;
- The role of a classroom aide assigned to the child, such as assistance in moving from one classroom to the next; and
- The characteristics of the child's self-contained classroom, such as teacher-student ratio.

This information about supports children receive can be critical to determining the extent to which their impairments compromise their ability to independently initiate, sustain, and complete activities. In general, if a child needs a person, a structured or supportive setting, medication, treatment, or a device to improve or enable functioning, the child will not be as independent as same-aged peers who do not have impairments. We will generally find that such a child has a limitation, even if the child is functioning well with the help or support. The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independently the child functions, and the more severe we will find the limitation to be.¹⁸

1. *Present Level of Development or Educational Performance.* The first part of an IFSP or IEP describes and analyzes the child's present level of development (for example, physical or cognitive development) or academic skills based on the comprehensive evaluation or subsequent assessments and other information that is available at the time the IFSP or IEP is developed.¹⁹

2. *Goals and Objectives.* The second part of an IFSP or IEP consists of one or more sets of goals and specific objectives for the infant or toddler's development or the preschool or school-age child's education. The IFSP or IEP includes goals for improvement within 3–6 months (for infants and toddlers) or 1 year for preschool and school-age children. We can infer how the child is currently functioning from these goals. For example, if an IEP goal is "will be able to read at a 4th grade level," we can reasonably conclude that the child was not performing at that level when the IEP was written.

Based on broad developmental or educational goals, the written plan will outline specific objectives organized around the discrete physical or mental skills that must be mastered in order to achieve the goal. The plan also includes the kinds of activities and tasks the teacher or therapist will undertake with the child to develop the targeted skills. For example:

- An IFSP goal for a toddler from an occupational therapist might be: "The child will use fine/gross motor skills to handle age-appropriate materials during play," while a specific objective (one of many) would identify the skills to be developed (for example, articulation of the thumb and all fingers for grasping) and the particular manipulative tasks to be used to develop the needed skills (for example, molding modeling clay into balls).
- An IEP goal for an 11-year-old from a special educator might be: "The child will independently read simple stories at the 4th grade level," while a specific objective (one of many) would identify the skills to be developed (for example, use of phonetic cues to identify initial, medial, and ending sounds in new words), and the particular instruction methods to be used to develop the needed skills (for example, small group instruction with practice sounding out unfamiliar words).

Children who reach age 14 begin the transition from high school to the adult workplace. The IEP transition plan describes a student's levels of functioning based on reasonable estimates by both the student and the special education team and identifies the kinds of vocational and living skills the child needs to develop in order to move into adulthood. The IEP transition goals may range from the development of skills appropriate to supervised and supported work and living settings to those needed in independent work and living situations.

therefore, may indicate that there is other relevant evidence available.

¹⁷ The evaluation team may include personnel who are "acceptable medical sources" under our rules. When the team includes such people, the comprehensive evaluation may provide the primary evidence we need to both establish and evaluate the child's impairment and resulting limitations.

¹⁸ See generally 20 CFR 416.924a(b). See also SSR 09–1p.

¹⁹ IFSPs and IEPs frequently reference underlying psychological or developmental testing, and

Both the IFSP and IEP can provide useful information about a child's functioning. However, the underlying purpose of these documents is not to determine disability under our rules. Rather, the IFSP or IEP is used to design the individualized services and supports a child needs to maximize growth and development or to participate in and progress in the general education curriculum. In contrast, we use the information in the IFSP or IEP to help determine if the child has marked and severe functional limitations.

It is important to remember, therefore, that the goals in an IFSP or IEP are frequently set at a level that the child can readily achieve to foster a sense of accomplishment. Those goals are frequently lower than what would be expected of a child the same age without impairments. In this regard:

- A child who achieves a goal may still have limitations. The child may have achieved the goal simply because it was set low, and may be developing or acquiring skills at a slower rate than children the same age without impairments.

- On the other hand, the fact that the child does not achieve a goal is likely an indication of the severity of the child's impairment-related limitations. However, the child's failure to achieve a goal does not, by itself, establish that the impairment(s) functionally equals the listings.

Therefore, we must consider the purpose of the goals provided in an IFSP or IEP. And, as with any single piece of evidence, we will consider facts, such as whether a child achieves goals in an IFSP or IEP, along with other relevant information in the case record.

3. *Services, Settings, and Supports.* The third part of the IFSP or IEP documents what services the child needs, the settings in which the services will be provided, and any supports the child needs. The services needed may include special education placement, early intervention services, related services (such as occupational therapy, counseling, and transportation services), and supplementary services (such as peer tutoring and a one-on-one aide). The settings for services may include any setting that is typical for the child's same-aged peers and classroom placement (described in a. below). The supports a child needs may include adaptive equipment (such as a special seat), assistive technology (such as a communication board), and accommodations (described in b. below).

The IFSP may have an additional section for "other services," which

outlines services that the child may be receiving from other sources. An EI program should coordinate the services a child needs with other State and Federal programs. If the IFSP identifies such services, we will request the information from the other programs unless we determine that the additional information would not affect the outcome of the case given the other evidence already in the record.

a. Classroom Placements

When a child receives special education services under an IEP, the IEP will include information about the setting where the child will receive the services. There is a continuum of alternative placements including, but not limited to:

- Regular classrooms,
- Regular classrooms with "pull-out" services, such as a resource room,
- Special education classrooms,
- Alternative schools,
- Day treatment programs, and
- Residential schools.

The decision to provide services in a particular setting may be based on factors other than the severity of the child's limitations. Therefore, details about the child's performance in school and other settings (for example, how well the child is performing) are important components of our analysis. As we explain in more detail in SSR 09-1p, we will consider the kinds and levels of the support the child receives.

b. Accommodations

Some students with impairments need accommodations in their educational program in order to participate in the general curriculum. In this context, accommodations are practices and procedures that allow a child to complete the same assignment or test as other students, but with a change in:

- *Presentation*, or how instruction or directions are delivered (for example, read orally to the child by an adult, or provided in large print, on audiotape, or via a screen reader).
- *Response*, or how the student solves problems or completes assignments (for example, using an augmentative communication device or dictating answers to a scribe).
- *Setting*, or how the environment is set up (for example, seating the child near the teacher or seating the child away from distractions).
- *Timing/Scheduling*, or the time period during which the lesson or assignment is scheduled (for example, allowing extra time to complete an assignment or scheduling tests around a child's medication regimen).

C. Section 504 Plans

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs and activities that receive Federal financial assistance.²⁰ Schools must provide a free, appropriate public education to each student with a disability.²¹ Children must receive educational and related aids and services that are designed to meet their educational needs, even if they are not provided any special education services under the Individuals with Disabilities Education Act (IDEA).²² Schools will conduct an evaluation of specific areas of educational need for children who have disabilities that limit their access to the educational setting. If a child is qualified under section 504, the school will have a written plan for the aids, services, and accommodations that will be provided. We will consider any section 504 plans when we request information from a child's school.

V. *Standard of Comparison*

Because we compare a child's functioning to the functioning of other children the same age who do not have impairments, we should understand the standard of comparison used by sources of the information. For example, a special education teacher may say a child is "doing well." Without knowing the standard of comparison, this could mean:

- Compared to that teacher's expectations for the child,
- Compared to other children in the special education class, or
- Compared to children the same age who do not have impairments.

Therefore, the adjudicator will consider both the standards used by the teacher or other source to rate the quality of the child's functioning and the characteristics of the group to whom the child is being compared. 20 CFR 416.924a(b)(3)(ii).

VI. *Resolving Inconsistencies in the Evidence*

Adjudicators should analyze and evaluate relevant evidence for consistency, and resolve any

²⁰ Public Law 93-112, section 504; 29 U.S.C. 794(a), as amended.

²¹ See 34 CFR 104.33(a). "Appropriate" in this context means the provision of regular or special education and related aids and services that (i) are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met and (ii) are based upon adherence to procedures that satisfy the requirements of the Department of Education's regulations. 34 CFR 104.33(b).

²² 20 U.S.C. 1400, *et seq.*

inconsistencies that need to be resolved.²³

After reviewing all of the relevant evidence, we determine whether there is sufficient evidence to make a finding about disability. "All of the relevant evidence" means:

- The relevant objective medical evidence and other relevant evidence from medical sources;
- Relevant information from other sources, such as school teachers, family members, or friends;
- The claimant's statements (including statements from the child's parent(s) or other caregivers); and
- Any other relevant evidence in the case record, including how the child functions over time and across settings.

If there is sufficient evidence and there are no inconsistencies in the case record, we will make a determination or decision. However, the fact that there is an inconsistency in the evidence does not automatically mean that we need to request additional evidence, or that we cannot make a determination or decision. Often, we will be able to resolve the issue with the evidence in the case record because most of the evidence or the most probative evidence outweighs the inconsistent evidence and additional information would not change the determination or decision.

Sometimes an inconsistency may not be "material"; that is, it may not have any effect on the outcome of the case or on any of the major findings. Obviously, an inconsistency would be immaterial if the decision would be fully favorable regardless of the resolution. For example, if one piece of evidence shows the child's birth weight as 950 grams and another shows it as 1025 grams, the inconsistency is not material because we would find that the child's impairment(s) functionally equals the listings under 20 CFR 416.926a(m)(6) based on either birth weight. Similarly, an inconsistency could also be immaterial in an unfavorable determination or decision when resolution of the inconsistency would not affect the outcome. This could occur, for example, if there is inconsistent evidence about a limitation in an activity, but no evidence supporting a rating of "marked" limitation of a relevant domain.

At other times, an apparent inconsistency may not be a true inconsistency. For example, the record

²³This basic policy is also contained in other rules on evidence, including 20 CFR 416.912, 416.913, 416.924a(a), 416.927, and 416.929. For our rules on how we consider test results, see also section 112.00D of the listings for IQ and other tests related to mental disorders, and 20 CFR 416.924a(a)(1)(ii) and 416.926a(b)(4) for all testing.

for a child with attention-deficit/hyperactivity disorder (AD/HD) may include good, longitudinal evidence of hyperactivity at home and in the classroom, but show a lack of hyperactivity during a CE. While this may appear to be an inconsistency, it is a well-known clinical phenomenon that children with some impairments (for example, AD/HD) may be calmer, less inattentive, or less out-of-control in a novel or one-to-one setting, such as a CE. See 20 CFR 416.924a(b)(6).²⁴

In some cases, the longitudinal history may reveal sudden, negative changes in the child's functioning; for example, a child who previously did well in school suddenly begins to fail. In these situations, we should try to ascertain the reason for these changes whenever they are material to the decision.

In all other cases in which the evidence is insufficient, including when a material inconsistency exists that we cannot resolve based on an evaluation of all of the relevant evidence in the case record, we will try to complete the record by requesting additional or clarifying information.²⁵

Effective Date: This SSR is effective on March 20, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing

²⁴This example highlights the importance of getting a full picture of the "whole child" and of our longstanding policy that we must consider each piece of evidence in the context of the remainder of the case record. Accepting the observation of the child's behavior or performance in an unusual setting, like a CE, without considering the rest of the evidence could lead to an erroneous conclusion about the child's overall functioning.

²⁵With respect to testing, we provide in 20 CFR 416.926a(b)(4)(iii) that we will try to resolve material inconsistencies between test scores and other information in the case record. We explain that, while it is our responsibility to resolve any material inconsistencies, the interpretation of a test is "primarily the responsibility of the psychologist or other professional who administered the test." If necessary, we may recontact the professional who administered the test for further clarification. However, we may also resolve an inconsistency with other information in the case record, by questioning other people who can provide us with information about a child's day-to-day functioning, or by purchasing a consultative examination. This regulation also provides that when we do not believe that a test score accurately indicates a child's abilities, we will document our reasons for not accepting the score in the case record, or in the decision at the administrative law judge hearing and Appeals Council levels (when the Appeals Council makes a decision).

Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring For Yourself"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 06–03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies; and Program Operations Manual System (POMS) DI 24515.055, DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9–3378 Filed 2–17–09; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062, Social Security Ruling, SSR 09–4p.]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–4p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Attending and completing tasks." It also explains our policy about that domain.

DATES: *Effective Date:* March 20, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based

Received—20 CFR 404.1520(b), 404.1571–.1576, 404.1584–.1593 and 416.971–.976 —0960–0059. SSA’s field offices use Form SSA–821–BK to obtain work information from recipients during the continuing disability review process, and whenever a work issue arises in SSI claims. SSA’s processing centers and Office of Disability and International Operations use the form to obtain post-adjudicative work issues from recipients’ by mail. The primary purpose of this form is to collect recipient employment information in order to determine whether or not recipients have worked in employment after becoming disabled and, if so, whether the work is substantial gainful activity. SSA will review and evaluate the data to determine if the recipient continues to meet the disability requirements of the law. The

respondents are Social Security disability applicants, beneficiaries, and SSI applicants. **Note:** SSA listed this information collection as an extension of an OMB-approved information collection in the 60-Day **Federal Register** Notice published on December 11, 2008; it is a revision of an OMB-approved information collection.

Type of Request: Revision of an OMB-approved information collection.

Number of Respondents: 300,000.

Frequency of Response: 1.

Average Burden Per Response: 10 minutes.

Estimated Annual Burden: 50,000 hours.

8. Application for Supplemental Security Income —20 CFR 416.305–416.335, Subpart C—0960–0444. Form SSA–8001–BK collects information SSA uses to determine an applicant’s

eligibility for SSI, and the amount of SSI payments. SSA employees secure this information during interviews conducted with members of the public who wish to file for SSI payments. SSA uses this form for two purposes: (1) To establish a disability claim, but defer the complete development of non-medical issues until SSA approves the disability, or (2) to formally deny SSI payments for non-medical reasons when information provided by the applicant results in ineligibility. The respondents are applicants for SSI payments.

Note: SSA listed this information collection as an extension of an OMB-approved information collection in the 60-Day **Federal Register** Notice published on December 11, 2008; it is a revision of an OMB-approved information collection.

Type of Request: Revision of an OMB-approved information collection.

Form type	Number of respondents	Number of minutes to complete form	Burden hours
MSSIC	711,135	15	177,784
MSSIC/Signature Proxy	237,045	14	55,311
Paper	19,351	18	5,805
Totals	967,531	238,900

9. Medicaid Use Report—20 CFR 416.268—0960–0267. SSA uses the information required by this regulation to determine if an individual is entitled to special SSI payments and, consequently, to Medicaid benefits. The respondents are SSI recipients for whom SSA has stopped payments based on earnings.

Type of Request: Extension of an OMB-approved information collection.

Number of Respondents: 60,000.

Frequency of Response: 1.

Average Burden Per Response: 3 minutes.

Estimated Annual Burden: 3,000 hours.

10. Claimant’s Recent Medical Treatment— 20 CFR 404.1512 and 416.912—0960–0292. Each claimant who requests a hearing before an ALJ has a right to such a hearing once the Disability Determination Service (DDS), at the reconsideration level, has denied the claim. For the hearing, SSA requests the claimant complete and return the HA–4631 if the claimant’s file does not reflect a current, complete medical history as the claimant proceeds through the appeals process. ALJs must obtain the information to update and complete the record and to verify the accuracy of the information. It is by this process ALJs can ascertain whether the claimant’s situation has changed. The

ALJ and hearing office staff use the response to make arrangements for consultative examination(s) and the attendance of an expert witness(es) at the hearing, if appropriate. During the hearing, the ALJ offers any completed questionnaires as exhibits and may use them to refresh the claimant’s memory, and to inquire into the matters at issue. The respondents are claimants requesting hearings on entitlement to OASDI benefits or SSI payments.

Type of Request: Extension of an OMB-Approved Information Collection

Number of Respondents: 350,000.

Frequency of Response: 1.

Average Burden Per Response: 10 minutes.

Estimated Annual Burden: 58,333 hours.

Dated: February 9, 2009.

John Biles,

Reports Clearance Officer, Center for Reports Clearance, Social Security Administration.
[FR Doc. E9–3171 Filed 2–13–09; 8:45 am]

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062]

Social Security Ruling, SSR 09–3p.; Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Acquiring and Using Information”

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–3p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Acquiring and using information.” It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability,

supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Acquiring and Using Information”

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Acquiring and using information.” It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix I; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is “disabled” if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in “marked and severe

functional limitations.”⁴ 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the *Listing of Impairments* (the listings)⁵ or *functionally equal* the listings (also referred to as “functional equivalence”). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child's impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
- (2) Attending and completing tasks,
- (3) Interacting and relating with others,
- (4) Moving about and manipulating objects,
- (5) Caring for yourself, and

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child's limitations in functioning, as described in the following paragraphs, we must consider any variations in the child's level of functioning to determine the impact of the chronic illness on the child's ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child's limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child's functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations.

(6) Health and physical well-being. 20 CFR 416.926a(b)(1).⁸

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation

General:

In the domain of “Acquiring and using information,” we consider a child's ability to learn information and to think about and use the information.

Children acquire and use information at all ages for many different purposes. For example:

- An infant shakes a rattle and learns that it will produce noise.
- A toddler learns how to play simple games.
- An older child learns how to read and do arithmetic, which enables the child to act more independently, such as to make a purchase.
- A teenager may learn the rules and mechanics for driving a car.

Accordingly, this domain considers more than just assessments of cognitive ability as measured by intelligence tests, academic achievement instruments, or grades in school.

Learning and thinking begin at birth. In early infancy, children learn primarily by exploring their world through the senses (sight, sound, taste, touch, and smell), but also through movement and imitation. As they go on to engage in play, children learn about concepts (for example, “color,” “shape,” “size,” and “weight”). As they learn that people, objects, and activities have names, they begin to understand that names are words, and words are symbols that “stand for” what is named. Over time, this understanding of concepts and symbols prepares children for using language to learn and think. Eventually, they are expected to learn to read, write, and do arithmetic, as well as to acquire new information—not only in school, but at home and in the community.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

Throughout the learning process, children have to think about and use the information they have learned. Thinking involves being able to perceive relationships (for example, over/under and near/far), reason, and make logical choices. Children may do these things by thinking in pictures, words, or both. For example, children may solve problems by watching and imitating what other people do (thinking in pictures), or by internally “talking” their way through them (thinking in words). Eventually, children should be able to use language to think about the world, understand others, and express themselves. As they learn more complex language, children should be able to combine ideas to solve problems and perform more complex tasks.

Both mental and physical impairments can affect a child’s ability to acquire and use information. In addition to mental retardation and learning disorders, many other mental disorders can cause limitations in the domain of “Acquiring and using information.” For example, children with anxiety disorders may be so fearful about failing that they cannot perform learning-related tasks at school, such as taking tests or making presentations. Physical impairments, such as speech and hearing disorders, may affect a child’s ability to learn, especially in the classroom. Other impairments that frequently have effects in this domain include, but are not limited to, traumatic brain injury, cerebral palsy, and meningitis.

As with limitations in any domain, we do not consider a limitation in the domain of “Acquiring and using information” unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty acquiring and using information from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

*Preschool and school evidence*¹⁰

Because much of a preschool or school-age child’s learning takes place in a school setting, preschool and school records are often a significant source of information about limitations in the domain of “Acquiring and using information.” Poor grades or

inconsistent academic performance are among the more obvious indicators of a limitation in this domain provided they result from a medically determinable mental or physical impairment(s). Other indications in school records that a mental or physical impairment(s) may be interfering with a child’s ability to acquire and use information include, but are not limited to:

- *Special education services*, such as assignment of a personal aide who helps the child with classroom activities in a regular classroom, remedial or compensatory teaching methods for academic subjects, or placement in a self-contained classroom.

- *Related services* to help the child benefit from special education, such as occupational, physical, or speech/language therapy, or psychological and counseling services.

- *Other accommodations* made for the child’s impairment(s), both inside and outside the classroom, such as front-row seating in the classroom, more time to take tests, having tests read to the student, or after-school tutoring.

The kind, level, and frequency of special education, related services, or other accommodations a child receives can provide helpful information about the severity of the child’s impairment(s). However, the lack of such indicators does not necessarily mean that a child has no limitations in this domain. For various reasons, some children’s limitations may go unnoticed until well along in their schooling, or the children may not receive the services that they need.¹¹ Therefore, when we assess a child’s abilities in any of the domains, we must compare the child’s functioning to the functioning of same-age children without impairments based on all relevant evidence in the case record.

Although we consider formal school evidence (such as grades and aptitude and achievement test scores) in determining the severity of a child’s limitations in this domain, we do not rely solely on such measures. We also consider evidence about the child’s ability to learn and think from medical and other non-medical sources (including the child, if the child is old enough to provide such information), and we assess limitations in this ability in all settings, not just in school.

¹¹ See 20 CFR 416.924a(b)(7)(iv), which states that “[t]he fact that you do or do not receive special education services does not, in itself, establish your actual limitations or abilities. Children are placed in special education settings, or are included in regular classrooms (with or without accommodation), for many reasons that may or may not be related to the level of their impairments.”

As already noted, we do not consider a limitation in acquiring and using information unless it results from a medically determinable impairment(s). Therefore, we do not consider limitations that are associated with academic underachievement by a student who does not have a physical or mental impairment that accounts for the limitations.

Effects in other domains:

Children who have limitations in the domain of “Acquiring and using information” may also have limitations in other domains. For example, mental impairments that affect a child’s ability to learn may also affect a child’s ability to attend or to complete tasks. In such cases, we evaluate limitations in both the domains of “Acquiring and using information” and “Attending and completing tasks.” Also, children who have language impairments often have limitations in both the domains of “Acquiring and using information” and “Interacting and relating with others.”

Children who have physical impairments that affect motor functioning, which we evaluate in the domain of “Moving about and manipulating objects,” may also have limitations in the domain of “Acquiring and using information.” Symptoms associated with a physical impairment(s), such as generalized or localized pain, may interfere with a child’s ability to concentrate (an effect that we evaluate in the domain of “Attending and completing tasks”), and this will often also have effects on the child’s ability in the domain of “Acquiring and using information.” Lastly, some medications for physical impairments may affect mental functioning, interfering with a child’s ability to pay attention, remember, or follow directions. We consider these effects in the domains of “Acquiring and using information,” “Attending and completing tasks,” or both.

Therefore, as in any case, we evaluate the effects of a child’s impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. Rating the limitations caused by a child’s impairment(s) in each and every domain that is affected is *not* “double-weighting” of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child’s impairment(s) in all domains involved in the child’s limited activities.¹²

¹² For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09–1p.

¹⁰ For this domain, early intervention records can be an important source of information for children from birth to the attainment of age 3. For more information about how we consider early intervention, preschool, school, and other evidence, see SSRs 09–1p and 09–2p.

Examples of typical functioning in the domain of “Acquiring and using information”:

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating a child’s impairment-related limitations in the domain of “Acquiring and using information,” we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to acquiring and using information.

1. *Newborns and young infants (birth to attainment of age 1):*

- Shows interest in and explores the environment (for example, reaches for a toy).
- Engages in random actions that eventually become purposeful (for example, shakes a rattle).
- Begins to recognize and anticipate routine situations and events (for example, smiles at the sight of a stroller).
- Begins to recognize and attach meaning to everyday sounds (for example, the telephone).
- Begins to recognize and respond to familiar words (for example, own name, the name of a family member, or the word for a favorite toy or activity).

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

- Learns how objects go together in different ways.
- Learns through pretending that actions can represent real things.
- Understands that words represent people, things, places, and activities.
- Refers to self and things by pointing and eventually naming.
- Learns concepts and solves simple problems by purposeful experimentation (for example, taking a toy apart), imitation, constructive play (for example, building with blocks), and pretend play activities.
- Makes simple choices between two things.
- Responds to increasingly complex instructions and questions.
- Produces an increasing number of words and grammatically correct simple sentences and questions.

3. *Preschool children (age 3 to attainment of age 6):*

- Develops readiness skills needed for learning to read (for example, listening to stories, rhyming words, or matching letters).
- Develops readiness skills needed for learning to do math (for example,

counting, sorting, or building with blocks).¹³

- Develops readiness skills needed for learning to write (for example, coloring, painting, copying shapes, or using scissors).
- Uses words to ask questions, give answers, describe things, provide explanations, and tell stories.
- Follows several unrelated directions (for example, “Put your toy in the box and get your coat on.”).
- Begins to understand the order of daily routines (for example, breakfast before lunch).
- Begins to understand and remember own accomplishments.
- Begins to understand increasingly complex concepts (for example, “time” as in yesterday, today, and tomorrow).

4. *School-age Children (age 6 to attainment of age 12):*

- Learns to read, write, and do simple arithmetic.
- Becomes interested in new subjects and activities (for example, science experiments and stories from history).
- Demonstrates learning by producing oral and written projects, solving arithmetic problems, taking tests, doing group work, and entering into class discussions.
- Applies learning in daily activities at home and in the community (for example, reading street signs, telling time, and making change).
- Uses increasingly complex language (vocabulary and grammar) to share information, ask questions, express ideas, and respond to the opinions of others.

5. *Adolescents (age 12 to attainment of age 18):*

- Continues to demonstrate learning in academic assignments (for example, in composition, during classroom discussion, and by school laboratory experiments).
- Applies learning in daily situations without assistance (for example, going to the store, getting a book from the library, or using public transportation).
- Comprehends and expresses simple and complex ideas using increasingly complex language in academic and daily living situations.
- Learns to apply knowledge in practical ways that will help in employment (for example, carrying out instructions, completing a job application, or being interviewed by a potential employer).
- Plans ahead for future activities.
- Begins realistic occupational planning.

¹³ When building with blocks, a child is learning mathematical concepts such as “size” and “volume.”

Examples of limitations in the domain of “Acquiring and using information”:

To further assist adjudicators in evaluating a child’s impairment-related limitations in the domain of “Acquiring and using information,” we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only limitations in this domain, nor do they necessarily describe a “marked” or an “extreme” limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child’s age. For example, a toddler would not be expected to be able to read, but a teenager would.¹⁴

- Does not demonstrate an understanding of words that describe concepts such as space, size, or time (for example, inside/outside, big/little, morning/night).
- Cannot rhyme words or the sounds in words.
- Has difficulty remembering what was learned in school the day before.
- Does not use language appropriate for age.
- Is not developing “readiness skills” the same as peers (for example, learning to count, reciting ABCs, scribbling).
- Is not reading, writing, or doing arithmetic at appropriate grade level.
- Has difficulty comprehending written or oral directions.
- Struggles with following simple instructions.
- Talks only in short, simple sentences.
- Has difficulty explaining things.

Effective date: This SSR is effective on March 19, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach; SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Attending and Completing Tasks”; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating with Others”; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Moving About and Manipulating Objects”; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Caring for Yourself”; SSR 09–8p, Title

¹⁴ See 20 CFR 416.924b.

XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being”; SSR 98–1p, Determining Medical Equivalence in Title XVI Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9–3379 Filed 2–13–09; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–5p]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating With Others”

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–5p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Interacting and relating with others.” It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner’s decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register**

that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,
Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating With Others”

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Interacting and relating with others.” It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is “disabled” if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in “marked and severe functional limitations.”⁴ 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of Impairments (the listings)⁵ or must *functionally equal* the listings, also referred to as “functional equivalence.” 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child’s activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child’s impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
- (2) Attending and completing tasks,
- (3) Interacting and relating with others,
- (4) Moving about and manipulating objects,
- (5) Caring for yourself, and
- (6) Health and physical well-being.

20 CFR 416.926a(b)(1).⁸

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child’s limitations in functioning, as described in the following paragraphs, we must consider any variations in the child’s level of functioning to determine the impact of the chronic illness on the child’s ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child’s limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child’s functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

inconsistencies that need to be resolved.²³

After reviewing all of the relevant evidence, we determine whether there is sufficient evidence to make a finding about disability. "All of the relevant evidence" means:

- The relevant objective medical evidence and other relevant evidence from medical sources;
- Relevant information from other sources, such as school teachers, family members, or friends;
- The claimant's statements (including statements from the child's parent(s) or other caregivers); and
- Any other relevant evidence in the case record, including how the child functions over time and across settings.

If there is sufficient evidence and there are no inconsistencies in the case record, we will make a determination or decision. However, the fact that there is an inconsistency in the evidence does not automatically mean that we need to request additional evidence, or that we cannot make a determination or decision. Often, we will be able to resolve the issue with the evidence in the case record because most of the evidence or the most probative evidence outweighs the inconsistent evidence and additional information would not change the determination or decision.

Sometimes an inconsistency may not be "material"; that is, it may not have any effect on the outcome of the case or on any of the major findings. Obviously, an inconsistency would be immaterial if the decision would be fully favorable regardless of the resolution. For example, if one piece of evidence shows the child's birth weight as 950 grams and another shows it as 1025 grams, the inconsistency is not material because we would find that the child's impairment(s) functionally equals the listings under 20 CFR 416.926a(m)(6) based on either birth weight. Similarly, an inconsistency could also be immaterial in an unfavorable determination or decision when resolution of the inconsistency would not affect the outcome. This could occur, for example, if there is inconsistent evidence about a limitation in an activity, but no evidence supporting a rating of "marked" limitation of a relevant domain.

At other times, an apparent inconsistency may not be a true inconsistency. For example, the record

²³ This basic policy is also contained in other rules on evidence, including 20 CFR 416.912, 416.913, 416.924a(a), 416.927, and 416.929. For our rules on how we consider test results, see also section 112.00D of the listings for IQ and other tests related to mental disorders, and 20 CFR 416.924a(a)(1)(ii) and 416.926a(b)(4) for all testing.

for a child with attention-deficit/hyperactivity disorder (AD/HD) may include good, longitudinal evidence of hyperactivity at home and in the classroom, but show a lack of hyperactivity during a CE. While this may appear to be an inconsistency, it is a well-known clinical phenomenon that children with some impairments (for example, AD/HD) may be calmer, less inattentive, or less out-of-control in a novel or one-to-one setting, such as a CE. See 20 CFR 416.924a(b)(6).²⁴

In some cases, the longitudinal history may reveal sudden, negative changes in the child's functioning; for example, a child who previously did well in school suddenly begins to fail. In these situations, we should try to ascertain the reason for these changes whenever they are material to the decision.

In all other cases in which the evidence is insufficient, including when a material inconsistency exists that we cannot resolve based on an evaluation of all of the relevant evidence in the case record, we will try to complete the record by requesting additional or clarifying information.²⁵

Effective Date: This SSR is effective on March 20, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing

²⁴ This example highlights the importance of getting a full picture of the "whole child" and of our longstanding policy that we must consider each piece of evidence in the context of the remainder of the case record. Accepting the observation of the child's behavior or performance in an unusual setting, like a CE, without considering the rest of the evidence could lead to an erroneous conclusion about the child's overall functioning.

²⁵ With respect to testing, we provide in 20 CFR 416.926a(b)(4)(iii) that we will try to resolve material inconsistencies between test scores and other information in the case record. We explain that, while it is our responsibility to resolve any material inconsistencies, the interpretation of a test is "primarily the responsibility of the psychologist or other professional who administered the test." If necessary, we may recontact the professional who administered the test for further clarification. However, we may also resolve an inconsistency with other information in the case record, by questioning other people who can provide us with information about a child's day-to-day functioning, or by purchasing a consultative examination. This regulation also provides that when we do not believe that a test score accurately indicates a child's abilities, we will document our reasons for not accepting the score in the case record, or in the decision at the administrative law judge hearing and Appeals Council levels (when the Appeals Council makes a decision).

Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring For Yourself"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 06–03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies; and Program Operations Manual System (POMS) DI 24515.055, DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062, Social Security Ruling, SSR 09–4p.]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–4p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Attending and completing tasks." It also explains our policy about that domain.

DATES: *Effective Date:* March 20, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based

on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Attending and Completing Tasks”

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Attending and completing tasks.” It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is “disabled” if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in “marked and severe functional limitations.”⁴ 20 CFR

416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of Impairments (the listings)⁵ or *functionally equal* the listings (also referred to as “functional equivalence”). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷ We next evaluate the effects of a child's impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
 - (2) Attending and completing tasks,
 - (3) Interacting and relating with others,
 - (4) Moving about and manipulating objects,
 - (5) Caring for yourself, and
 - (6) Health and physical well-being.
- 20 CFR 416.926a(b)(1).⁸

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child's limitations in functioning, as described in the following paragraphs, we must consider any variations in the child's level of functioning to determine the impact of the chronic illness on the child's ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child's limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child's functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of “Attending and completing tasks,” we consider a child's ability to focus and maintain attention, and to begin, carry through, and finish activities or tasks. We consider the child's ability to initiate and maintain attention, including the child's alertness and ability to focus on an activity or task despite distractions, and to perform tasks at an appropriate pace. We also consider the child's ability to change focus after completing a task and to avoid impulsive thinking and acting. Finally, we evaluate a child's ability to organize, plan ahead, prioritize competing tasks, and manage time.¹⁰

The ability to attend and to complete tasks develops throughout childhood, evolving from an infant's earliest response to stimuli, such as light, sound, and movement, to an adolescent's completion of academic requirements. Over time, this evolution can be seen in the steady development of a child's ability to attend and to complete increasingly complex tasks. For example:

- Newborns or young infants gaze at human faces or moving objects, and listen in the direction of a human voice.
- Toddlers engage in activities that interest them, such as listening to a story.

¹ to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹⁰ In 20 CFR 416.924a(b)(5), we provide that how independently a child can “initiate, sustain, and complete” activities is a “factor” we consider when evaluating a child's functioning. The difference between this “factor” and the domain of “Attending and completing tasks” is that the factor addresses the issue of independence in functioning at every step in the sequential evaluation process and in all domains—the extent to which a child can begin, carry out, and finish age-appropriate activities at an appropriate rate and without needing extra help. The child may receive help in a number of ways: Personal service from another person; special equipment, devices, or medications; adaptations (such as special appliances); and structured or supportive settings, including the amount of help the child needs to remain in a regular setting. The domain of “Attending and completing tasks” assesses a child's specific ability to focus and maintain attention.

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

- Preschool children engage in uninterrupted periods of play, such as putting a puzzle together.
- School-age children focus long enough to do classwork and homework.
- Adolescents may perform part-time work requiring sustained attention to assigned duties that must be completed on time.

As in any domain, when we evaluate a child's limitations in the domain of "Attending and completing tasks," we consider how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. For example, a teacher may report that a child "pays attention well with frequent prompting." The need for frequent prompting demonstrates that the child is not paying attention as appropriately, effectively, or independently as children of the same age who do not have impairments. Despite the fact that the child is paying attention with prompting, this child is not functioning well in this domain.

The domain of "Attending and completing tasks" covers only the mental aspects of task completion; such as the mental pace that a child can maintain to complete a task.¹¹ Therefore, limitations in the domain of "Attending and completing tasks" are most often seen in children with mental disorders. For example, in school:

- Children with attention-deficit/hyperactivity disorder (AD/HD) whose primary difficulty is *inattention* may be easily distracted or have difficulty focusing on what is important and staying on task. They may fail to pay close attention to details and make careless mistakes in schoolwork, avoid projects that require sustained attention, or lose things needed for school or other activities beyond what is expected of children their age who do not have impairments.

- Children with AD/HD whose primary difficulty is *hyperactivity* and

impulsivity may fidget with objects instead of paying attention, talk instead of listening to instructions, or get up from their desks and wander around the classroom beyond what is expected of children their age who do not have impairments.¹²

Although we more often see limitations in this domain in connection with mental disorders, a physical impairment(s) can also affect a child's mental ability to attend and to complete tasks. For example, pain caused by a musculoskeletal disorder can distract a child and interfere with the child's ability to concentrate and to complete assignments on time. Medications that affect concentration or interfere with other mental processes, such as some medications for seizure disorders, may also affect a child's ability to attend and to complete tasks.

Some children with impairments can attend to some tasks, but not to all tasks in all settings. Such children may exhibit "hyperfocus," an intense focus on things that interest them, such as video games, but be limited in their ability to focus on other tasks. These kinds of limitations in the domain of "Attending and completing tasks" are common in children with AD/HD and autistic spectrum disorders (ASD). For example, some children with ASD may be distracted by, or become fixated on, everyday sounds (such as the hum of an air conditioner) that children without impairments can easily ignore. Children with autism may become fixated on parts of an object (such as the wheels on a toy truck) rather than on the more obvious and primary use of the object. Children with Asperger's disorder (one type of ASD), may hyperfocus on a single area of interest and have difficulty discussing or paying attention to any other subject. These children may appear to function well, or even better than other children, in the area of hyperfocus, but may be very limited in some other tasks and settings.

As with limitations in any domain, we do not consider a limitation in the domain of "Attending and completing tasks" unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty attending and completing tasks from time to time, a child who has significant but unexplained problems in this domain

may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

Effects in Other Domains

In the domain of "Attending and completing tasks," we consider the mental aspects of a child's ability to focus, maintain attention, and complete age-appropriate tasks throughout the day. In addition, because the ability to attend and to complete tasks is involved in nearly everything a child does, an impairment(s) that affects this ability may cause limitations in other domains.

For example, school-age children with AD/HD may have limitations in multiple domains. The effects of inattention and hyperactivity can impede the learning process and affect competence in many areas of life. These effects can result in limitations in the domain of "Acquiring and using information"; for example, by undermining academic performance. They may also have effects in the domain of "Interacting and relating with others"; for example, children with AD/HD may interrupt others in conversation or have difficulty taking turns during play activities. They may also cause limitations in the domain of "Caring for yourself"; for example, when a child risks personal safety by not stopping and thinking before doing something.

Therefore, as in any case, we evaluate the effects of a child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is *not* "double-weighting" of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.¹³

Examples of Typical Functioning in the Domain of "Attending and Completing Tasks"

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Attending and completing tasks," we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and

¹¹ We evaluate a child's *physical* ability to complete tasks in the domain of "Moving about and manipulating objects," or when appropriate, "Health and physical well-being." For example, a child who has difficulty getting dressed at an age-appropriate pace because of rheumatoid arthritis has a limitation that we evaluate in the domain of "Moving about and manipulating objects" or "Health and physical well-being" depending on the specific physical reason for the limitation; for example, joint deformity (Moving about and manipulating objects) or constitutional symptoms and signs (Health and physical well-being). A physical impairment may have effects that we evaluate in both the domains of "Moving about and manipulating objects" and "Health and physical well-being"; such as when a child has both a musculoskeletal deformity and constitutional symptoms and signs because of systemic sclerosis. In addition to the SSRs for the other domains cited at the end of this SSR, see generally SSR 09-1p.

¹² We provide a number of examples involving AD/HD and autism spectrum disorders in this SSR because these impairments frequently occur in childhood SSI cases. However, many other kinds of mental disorders can cause limitations in the ability to attend and to complete tasks. For example, mood disorders, such as depression, often cause difficulties in concentration.

¹³ For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09-1p.

adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to attending and completing tasks.

1. Newborns and Young Infants (Birth to Attainment of Age 1)

- Shows sensitivity to environment by responding to various stimuli (for example, light, touch, temperature, movement).
- Stops activity when voices or other sounds are heard.
- Begins to notice and gaze at various moving objects, including people and toys.
- Listens to family conversations and plays with people and toys for progressively longer periods of time.
- Wants to change activities frequently, but gradually expands interest in continuing an interaction or a game.

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Attends to things of interest (for example, looking at picture books, listening to stories).
- Has adequate attention to complete some tasks independently (for example, putting a toy away).
- Demonstrates sustained attention (for example, building with blocks, helping to put on clothes).

3. Preschool Children (Age 3 to Attainment of Age 6)

- Pays attention when spoken to directly.
- Sustains attention to play and learning activities.
- Concentrates on activities like putting puzzles together or completing art projects.
- Focuses long enough to complete many activities independently (for example, getting dressed, eating).
- Takes turns and changes activities when told by a caregiver or teacher that it is time to do something else.
- Plays contentedly and independently without constant supervision.

4. School-age Children (Age 6 to Attainment of Age 12)

- Focuses attention in a variety of situations in order to follow directions, completes school assignments, and remembers and organizes school-related materials.
- Concentrates on details and avoids making careless mistakes.
- Changes activities or routines without distracting self or others.

- Sustains attention well enough to participate in group sports, read alone, and complete family chores.

- Completes a transition task without extra reminders or supervision (for example, changing clothes after gym or going to another classroom at the end of a lesson).

5. Adolescents (Age 12 to Attainment of Age 18)

- Pays attention to increasingly longer presentations and discussions.
- Maintains concentration while reading textbooks.
- Plans and completes long-range academic projects independently.
- Organizes materials and manages time in order to complete school assignments.
- Maintains attention on tasks for extended periods of time, and is not unduly distracted by or distracting to peers in a school or work setting.

Examples of Limitations in the Domain of "Attending and Completing Tasks"

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Attending and completing tasks," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a toddler would not be expected to be able to play a game or stay on another task for an hour, but a teenager would.¹⁴

- Is easily startled, distracted, or overreactive to everyday sounds.
- Is slow to focus on or fails to complete activities that interest the child.
- Gives up easily on tasks that are within the child's capabilities.
- Repeatedly becomes sidetracked from activities or frequently interrupts others.
- Needs extra supervision to stay on task.
- Cannot plan, manage time, or organize self in order to complete assignments or chores.

Effective date: This SSR is effective upon publication in the **Federal Register**.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability

under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using information"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 98–1p, Determining Medical Equivalence in Title XVI Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9–3380 Filed 2–17–09; 8:45 am]

BILLING CODE 4191-02-P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Supplemental Notice of Meeting of the National Parks Overflights Advisory Group Aviation Rulemaking Committee

ACTION: Revised notice of meeting and additional information.

SUMMARY: The Federal Aviation Administration (FAA) and the National Park Service (NPS), in accordance with the National Parks Air Tour Management Act of 2000, announce the next meeting of the National Parks Overflights Advisory Group (NPOAG) Aviation Rulemaking Committee (ARC). This notification provides the date, format, and agenda for the meeting and provides additional information to the **Federal Register** notice published on February 3, 2009 (Vol. 74, No. 21, Page 5969) by providing the call in number for the public to access the telcon.

Dates and Location: The NPOAG ARC will hold a meeting on February 25th, 2009. The meeting will be conducted as a telephone conference call. The meeting will be held from 9 a.m. to 12 p.m. Pacific Standard Time on February 25th. This NPOAG meeting will be open

¹⁴ See 20 CFR 416.924b.

XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being”; SSR 98–1p, Determining Medical Equivalence in Title XVI Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9–3379 Filed 2–13–09; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–5p]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating With Others”

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–5p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Interacting and relating with others.” It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner’s decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register**

that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,
Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Interacting and Relating With Others”

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Interacting and relating with others.” It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is “disabled” if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in “marked and severe functional limitations.”⁴ 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of Impairments (the listings)⁵ or must *functionally equal* the listings, also referred to as “functional equivalence.” 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child’s activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child’s impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
- (2) Attending and completing tasks,
- (3) Interacting and relating with others,
- (4) Moving about and manipulating objects,
- (5) Caring for yourself, and
- (6) Health and physical well-being.

20 CFR 416.926a(b)(1).⁸

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child’s limitations in functioning, as described in the following paragraphs, we must consider any variations in the child’s level of functioning to determine the impact of the chronic illness on the child’s ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child’s limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child’s functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of “Interacting and relating with others,” we consider a child’s ability to initiate and respond to exchanges with other people, and to form and sustain relationships with family members, friends, and others. This domain includes all aspects of social interaction with individuals and groups at home, at school, and in the community. Important aspects of both interacting and relating are the child’s response to persons in authority, compliance with rules, and regard for the possessions of others. In addition, because communication is essential to both interacting and relating, we consider in this domain the speech and language skills children need to speak intelligibly and to understand and use the language of their community.

The ability to interact and relate with others begins at birth. Children begin to use this ability in early infancy when they bond with caregivers, and use it in increasingly complicated ways as they develop and grow older.

This ability is involved in a broad range of childhood activities, such as playing, learning, and working cooperatively with others, either one-on-one or in groups. To interact and relate effectively in any activity, a child must be able to recognize, understand, and respond appropriately to emotional and behavioral cues from other people. A child whose impairment(s) limits the ability to interact and relate with others may have various kinds of difficulties. For example, the child may not understand:

- How to approach other children,
- How to initiate and sustain social exchanges, and
- How to develop meaningful relationships with others.

Children with impairment-related limitations in this domain may not be disruptive; therefore, their limitations may go unnoticed. Such children may be described as socially withdrawn or isolated, without friends, or preferring to be left alone. These children may simply not understand how to accomplish social acceptance and integration with other individuals or groups.¹⁰ However, because children

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹⁰ The mere fact that a child prefers to be alone or does not have many friends, however, does not necessarily mean that there is a limitation that should be evaluated in this domain. There must be a limitation that results from a medically determinable impairment(s).

achieve much of their understanding about themselves and the world from their interactions, the impairment-related limitations of children who withdraw from social interaction may be as significant as those of children whose impairments cause them to be disruptive.

As with limitations in any domain, we do not consider a limitation in the domain of “Interacting and relating with others” unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty interacting and relating with others from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

Interacting With Others

To interact effectively with others, children must understand how to approach another person or a group of people, and must know how to respond in an age-appropriate manner to others who approach them. They must be able to use not only words, but facial expressions, gestures, and actions. The child must also be able to use these forms of communication with different people and in different contexts throughout the day. In addition, when interacting with a parent, teacher, or other adult, the child needs to convey respect for the adult. When interacting with peers, the child needs to convey willingness to play fairly and follow the rules, consistent with expectations for the child’s age. A child’s interactions may be limited to a single exchange, as when buying candy at a neighborhood store, or more frequent ones, as when answering a younger sibling’s questions. They may occur one-on-one, as when talking on the telephone, or in groups, as when playing with friends or participating in an organized sport.

Both physical and mental impairments can affect a child’s ability to interact with others. For example, a child with a hearing impairment or abnormality of the speech mechanism (such as a repaired cleft palate) may have speech that is difficult to understand. Such a child may have difficulty describing an event to strangers. A child with attention-deficit/hyperactivity disorder may antagonize others by impulsively cutting into a line.

Relating With Others

To relate effectively with others, a child must be able to form relationships

with family members, friends, and others, and to sustain those relationships over time in an age-appropriate manner. Creating relationships with others builds upon effective interaction, and involves awareness and consideration of others’ feelings, helpful and cooperative behaviors, and continuing interest in the relationships.

Both physical and mental impairments can affect a child’s ability to relate with others. For example, a child with a physical abnormality, such as a disfiguring burn, a missing limb, or an abnormal gait, or who uses adaptive equipment because of the impairment(s), may have difficulty making friends. A child with an anxiety disorder may be extremely uncomfortable around other children and may have difficulty spending enough time with others to maintain friendships. An autism spectrum disorder may limit a child’s emotional and social responses to others.

The role of communication in interacting and relating with others

The ability to interact and relate with others requires the ability to communicate in an age-appropriate manner.¹¹ To communicate with others, a child needs both *speech* and *language*. *Speech* is the production of sounds for the purpose of oral communication.¹² *Language* provides the message of communication. It involves understanding what is heard and read (*receptive language*) and expressing what one wants to say to others, either orally or in writing (*expressive language*).¹³ Within age-appropriate expectations, a child must speak clearly enough to be understood, understand the message that another person is communicating, and formulate sentences well enough to convey a

¹¹ The ability to communicate is first manifested at birth. Even before speaking their first words, infants communicate through gestures and vocalizations to express feelings and needs.

¹² In addition to *articulation* (which relates to clarity), speech also concerns *fluency* (which relates to the flow of speech) and *voice* (which relates to vocal quality, pitch, and intensity). For a comprehensive discussion of speech issues in childhood disability cases, including guidelines for evaluating the severity of speech impairments, see SSR 98–1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech.

¹³ When we evaluate the communication ability of children who speak a language other than English, we consider their use of their primary language (first language learned) and English. Otherwise, we might erroneously find limitations in “Interacting and relating with others” (or any other domain) when children are, for example, simply learning a second language or demonstrating dialectal differences.

message. An impairment(s) may affect speech, language, or both speech and language.

Communication involves using and understanding both verbal and nonverbal skills in conversation. This is the social aspect of communication, also referred to as *pragmatics*. It involves *verbal* skills related to vocabulary choice and sentence formulation, and *non-verbal* skills, such as maintaining eye contact and using gestures, facial expressions, and physical postures.¹⁴ It also involves other “rules” or conversational skills, such as turn-taking, introducing and maintaining a topic, asking for clarification or giving feedback when appropriate, and using effective techniques for opening, maintaining, and closing a conversation.

When *speaking* in a conversation, a child must decide what to say and how to say it, using appropriate vocabulary and following the rules of grammar to communicate the intended message. In addition, the child must consider factors that can influence the expression of the message, including the identity of the listener (for example, parent, teacher, sibling, or friend) and the child’s relationship to the listener (for example, how the child states a request to an authority figure or to a peer). The child must also pay attention to verbal and nonverbal indications of whether the listener understands the message and, if not, must be able to rephrase the message so as to be understood.

When *listening* in a conversation, a child must follow what is being communicated well enough to understand the message and, if a response is appropriate, to respond in a meaningful way. A child who has difficulty understanding either the verbal or the nonverbal message may not be able to participate appropriately in a conversation. For example, classmates may become impatient or irritated when a child is unable to understand a joke (verbal) or to interpret facial expressions (nonverbal).

The Difference Between the Domains of “Interacting and Relating With Others” and “Caring for Yourself”

The domains of “Interacting and relating with others” and “Caring for yourself” are related, but different from each other. The domain of “Interacting and relating with others” involves a child’s feelings and behavior in relation

to *other people* (as when the child is playing with other children, helping a grandparent, or listening carefully to a teacher). The domain of “Caring for yourself” involves a child’s feelings and behavior in relation to *self* (as when controlling stress in an age-appropriate manner).

A decision about which domain is appropriate for the evaluation of a specific limitation depends on the impact of the particular behavior. For example:

- If a girl with hyperactivity interrupts conversations inappropriately, we evaluate this problem in social functioning in the domain of “Interacting and relating with others.” However, if she impulsively runs into the street, endangering herself, we evaluate this problem in self-care in the domain of “Caring for yourself.”

- If a boy with a language disorder avoids other children during playtime, we evaluate this problem in social functioning in the domain of “Interacting and relating with others.” But the child may also use language for “self-talk” to calm himself down in a stressful situation, so the language disorder may cause a limitation in self-regulation, which we evaluate in the domain of “Caring for yourself.”

Some impairments may cause limitations in *both* domains. For example, a boy with Oppositional Defiant Disorder who refuses to obey a parent’s instruction not to run on a slippery surface, disrespects the parent’s authority and endangers himself by running instead of walking. In this case, the child’s mental disorder is causing limitations in the domains of “Interacting and relating with others” and “Caring for yourself.” Similarly, a teenage girl with depression who avoids friends and wants to be left alone may also develop poor eating habits as a way of coping with social isolation. We evaluate the limitations resulting from her depression in both the domains of “Interacting and relating with others” and “Caring for yourself.” Rating the limitations caused by a child’s impairment(s) in each and every domain that is affected is *not* “double-weighting” of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child’s impairment(s) in all domains involved in the child’s limited activities.¹⁵

Effects in Other Domains

Children with limitations in the ability to interact and relate with others

may also have limitations in other domains. For example, learning and thinking also require the ability to communicate, so an impairment(s) affecting communication may cause a limitation that we evaluate in the domain of “Acquiring and using information” in addition to the domain of “Interacting and relating with others.” Therefore, as in any case, we evaluate the effects of the child’s impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains.

Examples of Typical Functioning in the Domain of “Interacting and Relating With Others”

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating impairment-related limitations in the domain of “Interacting and relating with others,” we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to the ability to interact and relate with others.

1. Newborns and Young Infants (Birth to Attainment of Age 1)

- Begins to form intimate relationships (for example, by gradually responding visually and vocally to a caregiver, and by molding body to caregiver’s when held).
- Initiates early interactive games (for example, playing peek-a-boo or pat-a-cake).
- Responds to a variety of emotions (for example, returning a caregiver’s smile or crying when others are showing distress).
- Begins to develop speech (beginning with vowels and consonants, first alone and then combined in babbling sounds).

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Begins to separate from caregivers, although is still dependent on them.
- Expresses emotions and responds to the feelings of others.
- Initiates and maintains interactions with adults.
- Begins to understand concept of “mine” and “his” or “hers.”
- Shows interest in, plays alongside, and eventually interacts with other children.

¹⁴ A child’s cultural background may also influence pragmatic behaviors. For example, teachers in many Northern American cultures expect children to maintain eye contact during conversations. Children from Asian backgrounds, however, are often trained to show respect for authority figures by avoiding eye contact.

¹⁵ For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09–1p.

- Communicates wishes or needs, first with gestures and later with words that can be understood most of the time by people who know the child best.

3. Preschool Children (Age 3 to Attainment of Age 6)

- Socializes with children and adults. Begins to prefer and develops friendships with playmates the same age.

- Relates to caregivers with increasing independence.

- Uses words instead of actions to express self.

- Is better able to share, show affection, and offer help.

- Understands and obeys simple rules most of the time, and sometimes asks permission.

- Chooses own friends and plays cooperatively without continual adult supervision.

- Initiates and participates in conversations with familiar and unfamiliar listeners, using increasingly complex vocabulary and grammar.

- Speaks clearly enough to be understood by familiar and unfamiliar listeners most of the time.

4. School-Age Children (Age 6 to Attainment of Age 12)

- Develops more lasting friendships with same-age children.

- Increasingly understands how to work in groups to create projects and solve problems.

- Increasingly understands another's point of view and tolerates differences (for example, playing with children from diverse backgrounds).

- Attaches to adults other than parents (for example, teachers or club leaders), and may want to please them to gain attention.

- Shares ideas, tells stories, and speaks in a manner that can be readily understood by familiar and unfamiliar listeners.

5. Adolescents (Age 12 to Attainment of Age 18)

- Initiates and develops friendships with children of the same age.

- Relates appropriately to children of all ages and adults, both individually and in groups.

- Increasingly able to resolve conflicts between self and family members, peers, and others outside of family.

- Recognizes that there are different social rules for dealing with other children than with adults (for example, behaving casually with friends, but more formally with people in authority).

- Describes feelings, seeks information, relates events, and tells

stories in all kinds of environments (for example, at home or in school) and with all kinds of people (for example, parents, siblings, friends, or classmates).

- Develops increasing desire for privacy.

- Focuses less attention on parents and more on relationships with peers.

Examples of Limitations in the Domain of "Interacting and Relating With Others"

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Interacting and relating with others," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a toddler may be appropriately fearful of meeting new people, but a teenager would be expected to interact with strangers more readily.¹⁶

- Does not reach out to be picked up, touched, and held by a caregiver.

- Has no close friends, or has friends who are older or younger.

- Avoids or withdraws from people he or she knows.

- Is overly anxious or fearful of meeting new people or trying new experiences.

- Has difficulty cooperating with others.

- Has difficulty playing games or sports with rules.

- Has difficulty communicating with others (for example, does not speak intelligibly or use appropriate nonverbal cues when carrying on a conversation).

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09-1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09-2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09-3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09-4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09-6p, Title XVI: Determining Childhood Disability—The

Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09-7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; 09-8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 98-1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9-3382 Filed 2-13-09; 8:45 am]

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2008-0062]

Social Security Ruling, SSR 09-6p.; Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09-6p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Moving about and manipulating objects." It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 965-1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or

¹⁶ See 20 CFR 416.924b.

- Communicates wishes or needs, first with gestures and later with words that can be understood most of the time by people who know the child best.

3. Preschool Children (Age 3 to Attainment of Age 6)

- Socializes with children and adults. Begins to prefer and develops friendships with playmates the same age.

- Relates to caregivers with increasing independence.

- Uses words instead of actions to express self.

- Is better able to share, show affection, and offer help.

- Understands and obeys simple rules most of the time, and sometimes asks permission.

- Chooses own friends and plays cooperatively without continual adult supervision.

- Initiates and participates in conversations with familiar and unfamiliar listeners, using increasingly complex vocabulary and grammar.

- Speaks clearly enough to be understood by familiar and unfamiliar listeners most of the time.

4. School-Age Children (Age 6 to Attainment of Age 12)

- Develops more lasting friendships with same-age children.

- Increasingly understands how to work in groups to create projects and solve problems.

- Increasingly understands another's point of view and tolerates differences (for example, playing with children from diverse backgrounds).

- Attaches to adults other than parents (for example, teachers or club leaders), and may want to please them to gain attention.

- Shares ideas, tells stories, and speaks in a manner that can be readily understood by familiar and unfamiliar listeners.

5. Adolescents (Age 12 to Attainment of Age 18)

- Initiates and develops friendships with children of the same age.

- Relates appropriately to children of all ages and adults, both individually and in groups.

- Increasingly able to resolve conflicts between self and family members, peers, and others outside of family.

- Recognizes that there are different social rules for dealing with other children than with adults (for example, behaving casually with friends, but more formally with people in authority).

- Describes feelings, seeks information, relates events, and tells

stories in all kinds of environments (for example, at home or in school) and with all kinds of people (for example, parents, siblings, friends, or classmates).

- Develops increasing desire for privacy.

- Focuses less attention on parents and more on relationships with peers.

Examples of Limitations in the Domain of "Interacting and Relating With Others"

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Interacting and relating with others," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a toddler may be appropriately fearful of meeting new people, but a teenager would be expected to interact with strangers more readily.¹⁶

- Does not reach out to be picked up, touched, and held by a caregiver.

- Has no close friends, or has friends who are older or younger.

- Avoids or withdraws from people he or she knows.

- Is overly anxious or fearful of meeting new people or trying new experiences.

- Has difficulty cooperating with others.

- Has difficulty playing games or sports with rules.

- Has difficulty communicating with others (for example, does not speak intelligibly or use appropriate nonverbal cues when carrying on a conversation).

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09-1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09-2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09-3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09-4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09-6p, Title XVI: Determining Childhood Disability—The

Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09-7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; 09-8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 98-1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9-3382 Filed 2-13-09; 8:45 am]

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2008-0062]

Social Security Ruling, SSR 09-6p.; Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09-6p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Moving about and manipulating objects." It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 965-1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or

¹⁶ See 20 CFR 416.924b.

regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Moving About and Manipulating Objects”

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of “Moving about and manipulating objects.” It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is “disabled” if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in “marked and severe functional limitations.”⁴ 20 CFR 416.906. This means that the impairment(s) must *meet or medically equal* a listing in the Listing of Impairments (the listings),⁵ or

functionally equal the listings (also referred to as “functional equivalence”). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child’s activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child’s impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
 - (2) Attending and completing tasks,
 - (3) Interacting and relating with others,
 - (4) Moving about and manipulating objects,
 - (5) Caring for yourself, and
 - (6) Health and physical well-being.
- 20 CFR 416.926a(b)(1).⁸

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child’s limitations in functioning, as described in the following paragraphs, we must consider any variations in the child’s level of functioning to determine the impact of the chronic illness on the child’s ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child’s limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child’s functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of “Moving about and manipulating objects,” we consider the physical ability to move one’s body from one place to another, and to move and manipulate things. These activities may require gross or fine motor skills, or a combination of both.

Moving one’s body includes several kinds of actions, such as:

- Rolling,
- Rising or pulling up from a sitting position,
- Raising the head, arms, and legs,
- Twisting the hands and feet,
- Shifting weight while sitting or standing,
- Transferring from one surface to another,
- Lowering down to the floor, as when bending, kneeling, stooping, or crouching, and
- Moving forward and backward as when crawling, walking, running, and negotiating different terrains (for example, curbs, steps, and hills).

Moving and manipulating objects includes several kinds of actions, such as:

- Engaging the upper and lower body to push, pull, lift, or carry objects from one place to another,
- Controlling the shoulders, arms, and hands to hold or transfer objects, and
- Coordinating the eyes and hands to manipulate small objects or parts of objects.

All of these physical actions require children to exhibit varying degrees of strength, coordination, dexterity, and pace to accomplish a given task or activity (for example, getting dressed). They also require children to have a sense of where their bodies are in relation to the environment and an understanding of how their bodies move in space (for example, jumping rope). In addition, gross and fine motor skills require the integration of sensory input with motor output (for example, seeing a ball and catching it). Those skills also require the capacity for motor planning and motor memory, that is, the ability to plan, remember, and execute controlled movement (for example, riding a bicycle).

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

Both physical and mental impairments can affect a child's ability to move about and manipulate objects. For example:

- A child with a benign brain tumor may have difficulty with balance.
- A child with rheumatoid arthritis may have difficulty writing.
- A child with a developmental coordination disorder may be clumsy or have slow eye-hand coordination.

Some somatoform disorders can also have effects in this domain.

Some medications can affect a child's ability to move about and manipulate objects. For example, some antidepressant medications may cause hand tremors that interfere with fine motor skills. If these effects persist over time, we consider them in this domain.

As with limitations in any domain, we do not consider a limitation in the domain of "Moving about and manipulating objects" unless it results from a medically determinable impairment(s). However, while it is common for some children (especially younger children) to experience some difficulty in this area from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

The Difference Between the Domains of "Moving About and Manipulating Objects" and "Health and Physical Well-Being"

In the domain of "Moving about and manipulating objects," we consider how well children are able to move their own bodies and handle things. We evaluate limitations of fine and gross motor movements caused by musculoskeletal and neurological impairments, by other impairments (including mental disorders) that may result in motor limitations, and by medications or other treatments that cause such limitations.

In the domain of "Health and physical well-being," we consider the cumulative physical effects of physical and mental impairments and their associated treatments or therapies not addressed in the domain of "Moving about and manipulating objects." We evaluate the problems of children who are physically ill or who manifest physical effects of mental impairments (except for effects on motor functioning). Physical effects, such as pain, weakness, dizziness, nausea, reduced stamina, or recurrent infections, may result from the impairment(s) itself, from medications or other treatment, or from chronic illness. These effects can determine

whether a child feels well enough and has sufficient energy to engage in age-appropriate activities, either alone or with other children.¹⁰

In fact, an impairment(s) or its treatment may have effects in both domains when it affects fine or gross motor functioning *and* the child's general physical state. For example, some medications used to treat impairments that affect motor functioning may have physical effects (such as nausea, headaches, allergic reactions, or insomnia) that sap a child's energy or make the child feel ill. We evaluate these generalized, cumulative effects on the child's overall physical functioning in the domain of "Health and physical well-being." We evaluate any limitations in fine or gross motor functioning in the domain of "Moving about and manipulating objects."

Effects in Other Domains

Impairments that affect motor functioning and their associated treatments can have effects in other domains as well. For example, generalized or localized pain that results from an impairment(s) may interfere with a child's ability to concentrate, an effect that we evaluate in the domain of "Attending and completing tasks" and often in the domain of "Acquiring and using information." Pain may also cause a child to be less active socially, an effect that we evaluate in the domain of "Interacting and relating with others." Some medications for physical impairments may cause restlessness, agitation, or anxiety that may affect a child's social functioning (which we evaluate in the domain of "Interacting and relating with others") or emotional well-being (which we evaluate in the domain of "Caring for yourself").¹¹

Therefore, as in any case, we evaluate the effects of a child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is *not* "double-weighting" of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child's impairment(s) in all domains

¹⁰ For more information about the domain of "Health and physical well-being," see SSR 09-8p, Title XVI: Determining Childhood Disability: The Functional Equivalence Domain of "Health and Physical Well-Being."

¹¹ Further, a child may also have social difficulties because of a device used for treatment or assistance in functioning, such as a prosthesis for a missing limb or other adaptive equipment, that results in social stigma.

involved in the child's limited activities.¹²

Examples of Typical Functioning in the Domain of "Moving About and Manipulating Objects"

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Moving about and manipulating objects," we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to the development and use of gross and fine motor skills.

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

- Explores immediate environment by moving body and using limbs.
- Learns to hold head up, sit, crawl, and stand.
- Tries to hold onto a stable object and stand actively for brief periods.
- Begins to practice developing eye-hand control by reaching for objects or picking up small objects and dropping them into containers.

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

- Explores a wider area of the physical environment with steadily increasing body control and independence from others.
- Begins to walk and run without assistance, and climbs with increasing skill.
- Tries frequently to manipulate small objects and to use hands to do or get something wanted or needed.
- Uses improving motor skills to play with small blocks, scribble with crayons, and feed self.

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

- Walks and runs with ease.
- Climbs stairs and playground equipment with little supervision.
- Plays more independently (for example, rides a tricycle, swings self).
- Completes puzzles easily, strings beads, and builds with assortment of blocks.
- Uses crayons, markers, and small game pieces with increasing control.
- Cuts with scissors independently.
- Manipulates buttons and other fasteners.

¹² For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09-1p.

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

- Uses developing gross motor skills to move at an efficient pace at home, at school, and in the neighborhood.
- Uses increasing strength and coordination to participate in a variety of physical activities (for example, running, jumping, and throwing, kicking, catching and hitting balls).
- Applies developing fine motor skills to use many kitchen and household tools independently (for example, scissors).
- Writes with a pen or pencil.

5. *Adolescents (age 12 to attainment of age 18)*

- Uses motor skills to move easily and freely at home, at school, and in the community.
- Participates in a full range of individual and group physical fitness activities.
- Shows mature skills in activities requiring eye-hand coordination.
- Possesses the fine motor skills to write efficiently or type on a keyboard.

Examples of Limitations in the Domain of "Moving About and Manipulating Objects"

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Moving about and manipulating objects," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a teenager would be expected to run without difficulty, but a toddler would not.¹³

- Has muscle weakness, joint stiffness, or sensory loss that interferes with motor activities (for example, unintentionally drops things).
- Has trouble climbing up and down stairs, or has jerky or disorganized locomotion, or difficulty with balance.
- Has trouble coordinating gross motor movements (for example, bending, kneeling, crawling, running, jumping rope, or riding a bicycle).
- Has difficulty with sequencing hand or finger movements (for example, using utensils or manipulating buttons).
- Has difficulty with fine motor movements (for example, gripping and grasping objects).

- Has poor eye-hand coordination when using a pencil or scissors.

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[FR Doc. E9–3383 Filed 2–13–09; 8:45 am]

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–7p.]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–7p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Caring for yourself." It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT:

Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,
Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Caring for yourself." It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, 416.930, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any "individual" who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

¹³ See 20 CFR 416.924b.

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

- Uses developing gross motor skills to move at an efficient pace at home, at school, and in the neighborhood.
- Uses increasing strength and coordination to participate in a variety of physical activities (for example, running, jumping, and throwing, kicking, catching and hitting balls).
- Applies developing fine motor skills to use many kitchen and household tools independently (for example, scissors).
- Writes with a pen or pencil.

5. *Adolescents (age 12 to attainment of age 18)*

- Uses motor skills to move easily and freely at home, at school, and in the community.
- Participates in a full range of individual and group physical fitness activities.
- Shows mature skills in activities requiring eye-hand coordination.
- Possesses the fine motor skills to write efficiently or type on a keyboard.

Examples of Limitations in the Domain of "Moving About and Manipulating Objects"

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Moving about and manipulating objects," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a teenager would be expected to run without difficulty, but a toddler would not.¹³

- Has muscle weakness, joint stiffness, or sensory loss that interferes with motor activities (for example, unintentionally drops things).
- Has trouble climbing up and down stairs, or has jerky or disorganized locomotion, or difficulty with balance.
- Has trouble coordinating gross motor movements (for example, bending, kneeling, crawling, running, jumping rope, or riding a bicycle).
- Has difficulty with sequencing hand or finger movements (for example, using utensils or manipulating buttons).
- Has difficulty with fine motor movements (for example, gripping and grasping objects).

- Has poor eye-hand coordination when using a pencil or scissors.

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–7p.]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–7p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Caring for yourself." It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT:

Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,
Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Caring for yourself." It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, 416.930, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any "individual" who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

¹³ See 20 CFR 416.924b.

combination of impairments³ that results in “marked and severe functional limitations.”⁴ 20 CFR 416.906. This means that the impairment(s) must *meet or medically equal* a listing in the Listing of Impairments (the listings)⁵ or *functionally equal* the listings (also referred to as “functional equivalence”). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the “whole child” when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.⁶ We focus first on the child’s activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.⁷

We next evaluate the effects of a child’s impairment(s) by rating the degree to which the impairment(s) limits functioning in six “domains.” *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

- (1) Acquiring and using information,
- (2) Attending and completing tasks,

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child’s limitations in functioning, as described in the following paragraphs, we must consider any variations in the child’s level of functioning to determine the impact of the chronic illness on the child’s ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child’s limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child’s functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations.

(3) Interacting and relating with others,

(4) Moving about and manipulating objects,

(5) Caring for yourself, and

(6) Health and physical well-being.

20 CFR 416.926a(b)(1).⁸

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of “Caring for yourself,” we consider a child’s ability to maintain a healthy *emotional* and *physical* state. This includes:

- How well children get their emotional and physical wants and needs met in appropriate ways,
- How children cope with stress and changes in the environment, and
- How well children take care of their own health, possessions, and living area.

Although newborns and young infants are almost entirely dependent on caregivers for getting their emotional and physical wants and needs met, the ability to care for oneself is first manifested at birth. For example, a young infant who feels upset (an emotional need) or hungry (a physical need) may cry to alert a caregiver. As children mature, they are expected to deal with emotional and physical wants and needs with increasing competence and independence.

However, the domain of “Caring for yourself” does not address children’s *physical* abilities to perform self-care tasks like bathing, getting dressed, or cleaning up their room. We address these physical abilities in the domain of “Moving about and manipulating objects” and, if appropriate, “Health and physical well-being.”¹⁰ Nor does it

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of “Health and Physical Well-Being.”

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹⁰ A child may have limitations in the ability to do these self-care tasks because of impairment-related effects in other domains as well. For example, we evaluate the limitations of a child who has difficulty getting dressed because of an

concern the ability to relate to other people, which we address in the domain of “Interacting and relating with others.” Rather, in “Caring for yourself,” we focus on how well a child relates to *self* by maintaining a healthy emotional and physical state in ways that are age-appropriate and in comparison to other same-age children who do not have impairments.

A child may have limitations in the domain of “Caring for yourself” because of a mental or a physical impairment(s), medication, or other treatment. For example, if an adolescent who is prescribed a medication that causes weight gain frequently fails or refuses to take it because of embarrassment about his weight, thereby endangering his health, we would evaluate this limitation in the domain of “Caring for yourself.”¹¹

As with limitations in any domain, we do not consider a limitation in the domain of “Caring for yourself” unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty in this area from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

Emotional Wants and Needs

Children must learn to recognize and respond appropriately to their feelings in ways that meet their emotional wants and needs; for example, seeking comfort when sad, expressing enthusiasm and joy when glad, and showing anger safely when upset. To be successful as they mature, children must also be able to cope with negative feelings and express positive feelings appropriately. In

impairment that affects cognition in the domain of “Acquiring and using information.” See SSR 09–1p.

¹¹ We do not consider a child fully responsible for failing to follow prescribed treatment. Also, the policy of failure to follow prescribed treatment does not apply unless we first find that the child is disabled. Under this policy, we must also find that treatment was prescribed by the child’s “treating source” (as defined in 20 CFR 416.902) and that it is clearly expected that, with the treatment, the child would no longer be disabled. Even then, we must consider whether there is a “good reason” for the failure to follow the prescribed treatment. For example, if the child’s caregiver believes the side effects of treatment are unacceptable, or an adolescent refuses to take medication because of a mental disorder, we would find that there is a good reason for not following the prescribed treatment. However, if there is not a good reason and all the other requirements are met, a denial based on failure to follow prescribed treatment would be appropriate. See 20 CFR 416.930 and SSR 82–59, Titles II and XVI: Failure To Follow Prescribed Treatment.

addition, after experiencing any emotion, children must be able to return to a state of emotional equilibrium. The ability to experience, use, and express emotion is often referred to as *self-regulation*. Children should demonstrate an increased capacity to self-regulate as they develop.

Ordinary circumstances may cause emotions, such as fear, sadness, or frustration. Examples of age-appropriate, self-consoling activities to regulate such emotions include:

- For a newborn or young infant, sucking on a pacifier or thumb when upset.
- For a toddler, carrying a stuffed animal for a sense of security.
- For a preschool child, playing with a favorite toy when feeling lonely.
- For a school-age child, playing a computer game when bored.
- For an adolescent, listening to music when feeling stress.

However, children whose mental or physical impairments affect the ability to regulate their emotional well-being may respond in inappropriate ways. For example:

- A child with an anxiety disorder may use denial or escape rather than problem-solving skills to deal with a stressful situation.
- A child with attention-deficit/hyperactivity disorder who has difficulty completing assignments may express frustration by destroying school materials.
- A teenager with a depressive disorder may have adequate hygiene, but seek emotional comfort by engaging in self-injurious behaviors (for example, binge eating, substance abuse, or suicidal gestures).
- A child with a traumatic brain injury who has poor impulse control may have problems managing anger.
- A child with a musculoskeletal disorder who feels awkward and frustrated during recess time may refuse to leave the classroom.

Physical Wants and Needs

In addition to regulating emotional well-being, a child must be able to satisfy physical wants and needs every day. This requires children to have a basic understanding of their own bodies, including their bodies' normal functioning, and adequate emotional health for carrying out the tasks involved in self-care. The domain of "Caring for yourself" involves the emotional ability to engage in self-care activities, such as feeding, dressing, toileting, and maintaining hygiene and physical health.

Taking care of physical needs, however, also includes other aspects of self-care; for example:

- Recognizing when one feels ill,
- Seeking medical attention,
- Following safety rules,
- Asking for help when needed,
- Responding to circumstances in safe and appropriate ways, and
- Making decisions that do not endanger oneself.

The Difference Between the Domains of "Caring for Yourself" and "Interacting and Relating With Others"

The domains of "Caring for yourself" and "Interacting and relating with others" are related, but different from each other. The domain of "Caring for yourself" involves a child's feelings and behavior in relation to *self* (as when controlling stress in an age-appropriate manner). The domain of "Interacting and relating with others" involves a child's feelings and behavior in relation to *other people* (as when the child is playing with other children, helping a grandparent, or listening carefully to a teacher).

A decision about which domain is appropriate for the evaluation of a specific limitation depends on the impact of the particular behavior. For example:

- If a girl with hyperactivity impulsively runs into the street, endangering herself, we evaluate this problem in self-care in the domain of "Caring for yourself." On the other hand, if she interrupts conversations inappropriately, we evaluate this problem in social functioning in the domain of "Interacting and relating with others."
- If a language disorder limits a boy's ability to use "self-talk" to calm himself in a stressful situation, we evaluate this problem in self-regulation in the domain of "Caring for yourself." But if he avoids other children during playtime because of the language disorder, we evaluate this problem in social functioning in the domain of "Interacting and relating with others."

Some impairments may cause limitations in *both* domains. For example, a boy with Oppositional Defiant Disorder who refuses to obey a parent's instruction not to run on a slippery surface endangers himself and disrespects the parent's authority. In this case, the child's mental disorder is causing limitations in the domains of "Caring for yourself" and "Interacting and relating with others." Similarly, a teenage girl with depression who develops poor eating habits as a form of comfort, may also avoid friends and want to be left alone. We evaluate the

limitations resulting from her depression in both the domains of "Caring for yourself" and "Interacting and relating with others." Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is *not* "double-weighting" of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.¹²

Effects in Other Domains

Children with limitations in the domain of "Caring for yourself" may also have limitations in other domains. For example, children with impairments that affect self-regulation may have difficulties in school, resulting in a limitation in the domain of "Acquiring and using information" in addition to the domain of "Caring for yourself." Limitations in caring for self are also frequently found in connection with impairments whose most obvious effects are in other domains. For example, some children with learning disorders, which have effects in the domain of "Acquiring and using information," also have difficulties with self-regulation.

Therefore, as in any case, we evaluate the effects of the child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains.

Examples of Typical Functioning in the Domain of "Caring for Yourself"

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating impairment-related limitations in the domain of "Caring for yourself," we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to maintaining a healthy emotional and physical state.

1. Newborns and Young Infants (Birth to Attainment of Age 1)

- Responds to body's signals (for example, hunger, discomfort, pain) by alerting caregiver to needs (for example, crying).
- Consoles self until help comes (for example, sucking on a hand).

¹²For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09-1p.

- Begins to expand capacity for self-regulation to include rhythmic behaviors (for example, rocking).

- Tries to do things for self, perhaps when still too young (for example, insisting on putting food in mouth, refusing caregiver's help).

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Is increasingly able to console self (for example, carrying a favorite blanket).

- Cooperates with caregiver in dressing, bathing, and brushing teeth, but also shows what he can do (for example, pointing to the bathroom, pulling off coat).

- Insists on trying to feed self with spoon.

- Experiments with independence by a degree of contrariness (for example, "No! No!") and declaring own identity (for example, by hoarding toys).

3. Preschool Children (Age 3 to Attainment of Age 6)

- Tries to do things that he is not fully able to do (for example, climbing on chair to reach something up high).

- Agrees easily and early in this age range to do what caregiver wants, but gradually wants to do many things her own way or not at all.

- Develops more confidence in abilities (for example, wants to use toilet, feed self independently).

- Begins to understand how to control behaviors that are potentially dangerous (for example, crossing street without an adult).

4. School-Age Children (Age 6 to Attainment of Age 12)

- Recognizes circumstances that lead to feeling good and bad about himself.

- Begins to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior.

- Demonstrates consistent control over behavior and avoids behaviors that are unsafe.

- Begins to imitate more of the behavior of adults she knows.

- Performs most daily activities independently (for example, dressing, bathing), but may need to be reminded.

5. Adolescents (Age 12 to Attainment of Age 18)

- Discovers appropriate ways to express good and bad feelings (for example, keeps a diary, exercises).

- Feels more independent from others and becomes increasingly independent in all daily activities.

- Sometimes feels confused about how she feels about herself.

- Notices significant changes in his body's development, which can result

in some anxiety or worry about self and body (may sometimes cause anger and frustration).

- Begins to think about future plans (for example, work).

- Maintains personal hygiene adequately (for example, bathing, brushing teeth, wearing clean clothing appropriate for weather and context).

- Takes medications as prescribed.

Examples of Limitations in the Domain of "Caring for Yourself"

To further assist adjudicators in evaluating impairment-related limitations in the domain of "Caring for yourself," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, school-age children would be expected to bathe themselves, but toddlers would not; young children may place non-nutritive or inedible objects in their mouth, but older children typically would not.¹³

- Consoles self with activities that show developmental regression (for example, an older child who sucks his thumb).

- Has restrictive or stereotyped mannerisms (for example, head banging, body rocking).

- Does not spontaneously pursue enjoyable activities or interests (for example, listening to music, reading a book).

- Engages in self-injurious behavior (for example, refusal to take medication, self-mutilation, suicidal gestures) or ignores safety rules.

- Does not feed, dress, bathe, or toilet self appropriately for age.

- Has disturbance in eating or sleeping patterns.

- Places non-nutritive or inedible objects in mouth (for example, dirt, chalk).

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining

Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving and Manipulating Objects"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 82–59, Titles II and XVI: Failure To Follow Prescribed Treatment; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, DI 25225.055, DI 23010.001–23010.010, and DI 23010.020.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062]

Social Security Ruling, SSR 09–8p. Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well- Being"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–8p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Health and physical well-being." It also explains our policy about that domain.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

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- Begins to expand capacity for self-regulation to include rhythmic behaviors (for example, rocking).

- Tries to do things for self, perhaps when still too young (for example, insisting on putting food in mouth, refusing caregiver's help).

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Is increasingly able to console self (for example, carrying a favorite blanket).

- Cooperates with caregiver in dressing, bathing, and brushing teeth, but also shows what he can do (for example, pointing to the bathroom, pulling off coat).

- Insists on trying to feed self with spoon.

- Experiments with independence by a degree of contrariness (for example, "No! No!") and declaring own identity (for example, by hoarding toys).

3. Preschool Children (Age 3 to Attainment of Age 6)

- Tries to do things that he is not fully able to do (for example, climbing on chair to reach something up high).

- Agrees easily and early in this age range to do what caregiver wants, but gradually wants to do many things her own way or not at all.

- Develops more confidence in abilities (for example, wants to use toilet, feed self independently).

- Begins to understand how to control behaviors that are potentially dangerous (for example, crossing street without an adult).

4. School-Age Children (Age 6 to Attainment of Age 12)

- Recognizes circumstances that lead to feeling good and bad about himself.

- Begins to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior.

- Demonstrates consistent control over behavior and avoids behaviors that are unsafe.

- Begins to imitate more of the behavior of adults she knows.

- Performs most daily activities independently (for example, dressing, bathing), but may need to be reminded.

5. Adolescents (Age 12 to Attainment of Age 18)

- Discovers appropriate ways to express good and bad feelings (for example, keeps a diary, exercises).

- Feels more independent from others and becomes increasingly independent in all daily activities.

- Sometimes feels confused about how she feels about herself.

- Notices significant changes in his body's development, which can result

in some anxiety or worry about self and body (may sometimes cause anger and frustration).

- Begins to think about future plans (for example, work).

- Maintains personal hygiene adequately (for example, bathing, brushing teeth, wearing clean clothing appropriate for weather and context).

- Takes medications as prescribed.

Examples of Limitations in the Domain of "Caring for Yourself"

To further assist adjudicators in evaluating impairment-related limitations in the domain of "Caring for yourself," we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, school-age children would be expected to bathe themselves, but toddlers would not; young children may place non-nutritive or inedible objects in their mouth, but older children typically would not.¹³

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062]

Social Security Ruling, SSR 09–8p. Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well- Being"

AGENCY: Social Security Administration.
ACTION: Notice of Social Security Ruling (SSR).

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Commissioner of Social Security.

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- (1) Acquiring and using information,
 - (2) Attending and completing tasks,
 - (3) Interacting and relating with others,
 - (4) Moving about and manipulating objects,
 - (5) Caring for yourself, and
 - (6) Health and physical well-being.
- 20 CFR 416.926a(b)(1).⁸

⁵ For each major body system, the listings describe impairments we consider severe enough to cause “marked and severe functional limitations.” 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

⁶ See SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The “Whole Child” Approach.

⁷ However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child’s limitations in functioning, as described in the following paragraphs, we must consider any variations in the child’s level of functioning to determine the impact of the chronic illness on the child’s ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child’s limitations, see SSR 09–1p. For a comprehensive discussion of how we document a child’s functioning, including evidentiary sources, see SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child’s Impairment-Related Limitations.

⁸ For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in “marked” limitations in two domains of functioning or an “extreme” limitation in one domain.⁹ 20 CFR 416.926a(a).

Policy Interpretation:

General

In the domain of “Health and physical well-being,” we consider the cumulative physical effects of physical and mental impairments and their associated treatments on a child’s health and functioning. Unlike the other five domains of functional equivalence (which address a child’s abilities), this domain does not address typical development and functioning.¹⁰ Rather, the “Health and physical well-being” domain addresses how such things as recurrent illness, the side effects of medication, and the need for ongoing treatment affect a child’s body; that is, the child’s health and sense of physical well-being.¹¹

Some physical effects that we consider in this domain can result *directly from a physical or mental impairment(s)*. For example:

- Feeling weak, dizzy, agitated, short of breath, fatigued, low in energy, short on stamina, or “slowed down” (as with psychomotor retardation),¹² or having local or generalized pain; and

¹ to attainment of age 3; preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because, as we explain in this SSR, that domain does not address typical development and functioning.

⁹ See 20 CFR 416.926a(e) for definitions of the terms “marked” and “extreme.”

¹⁰ For more information about the other five domains of functional equivalence, see the cross-references at the end of this SSR.

¹¹ In 20 CFR 416.924a(b)(8) and (b)(9), we provide that “the impact of chronic illness” and “effects of treatment” are “factors” we consider when evaluating a child’s functioning. The difference between these “factors” and the domain of “Health and physical well-being” is that the factors address any kind of effect (physical or mental) that a child’s impairment(s) has on functioning, and we consider those effects at every step in the sequential evaluation process. However, we consider the domain only when determining whether a child’s impairment(s) “functionally equals the listings,” and the domain addresses only the physical effects of a child’s physical or mental impairment(s) (including associated treatment) on a child’s overall health.

¹² Most pediatricians and developmental specialists use the term “psychomotor retardation” to describe children with some combination of cognitive, communicative, and motor limitations. However, psychiatrists and psychologists use the term in a more restricted sense, to mean the motor effects of psychiatric disorders, such as the slow or limited movement that may be seen in a seriously depressed individual. In our regulation describing this domain (20 CFR 416.926a(l)) and in our mental disorders listings, the term has the same meaning

Continued

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any “individual” who has not attained age 18. In this SSR, we use the word “child” to refer to any such person, regardless of whether the person is considered a “child” for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term “impairment(s)” in this SSR to refer to an “impairment or a combination of impairments.”

⁴ The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

- Allergic reactions, recurrent infections, poor growth, bladder or bowel incontinence, changes in weight or eating habits, stomach discomfort, nausea, seizures or convulsive activity, headaches, or insomnia.

These and other physical effects can also be *the consequence of treatment* a child receives. For example:

- *Medications* for physical or mental disorders can cause generalized symptoms, such as fatigue, dizziness, or drowsiness, or more specific problems, such as nausea or weight loss. Certain medications used to treat mental disorders can have indirect physical effects. For example, some medications used to treat attention-deficit/hyperactivity disorder may cause a change in eating habits which may, in turn, limit growth.

- *Therapy* (for example, chemotherapy, multiple surgeries or procedures, chelation, pulmonary cleansing, or nebulizer treatments) can have physical effects, including generalized symptoms, such as weakness, or more specific problems, such as nausea. In addition, periods of therapy can be frequent or time-consuming, require recovery time, or reduce a child's endurance.

There are other considerations in this domain. For example:

- A child who otherwise appears to be functioning appropriately may be doing so because of intensive medical or other care needed to maintain health and physical well-being. We evaluate such medical fragility in this domain.

- Some disorders (for example, cystic fibrosis and asthma) are episodic, with periods of worsening (exacerbation) and improvement (remission). When symptoms and signs fluctuate, we consider the frequency and duration of exacerbations, as well as the extent to which they affect a child's ability to function physically.¹³

In all cases, it is important to remember that the cumulative physical effects of a child's physical or mental impairment(s) can vary in kind and intensity, and can affect each child differently.

as it does for psychiatrists and psychologists. Because different specialists use the term differently, it is important to read carefully any evidence that uses this term in order to determine how it is being used.

¹³ We generally do not consider brief episodes of illness (for example, ear infections) in this domain because they would not meet the duration requirement. However, there are certain impairments, such as immune deficiency diseases, that increase a child's susceptibility to infection or other disorders. In the domain of "Health and physical well-being," we consider such episodes of illness when they are associated with the child's underlying impairment.

As with limitations in any domain, we do not consider a limitation in the domain of "Health and physical well-being" unless it results from a medically determinable impairment(s). However, it is unlikely that a child who has a *significant* problem in this domain does not have an impairment(s) that causes the problem. Therefore, if a child has a significant problem in this domain, and there is no evidence of a medically determinable impairment(s) that could be the cause of the limitations, adjudicators should ensure that they have made all necessary attempts to obtain evidence of an impairment(s) and explain any finding that there is no medically determinable impairment(s) to account for the limitations in the determination or decision.

The Difference Between the Domains of "Health and Physical Well-Being" and "Moving About and Manipulating Objects"

In the domain of "Health and physical well-being," we consider the cumulative physical effects of physical and mental impairments and their associated treatments or therapies not addressed in the domain of "Moving about and manipulating objects." We evaluate the problems of children who are physically ill or who manifest physical effects of mental disorders (except for effects on motor functioning). Physical effects, such as pain, weakness, dizziness, nausea, reduced stamina, or recurrent infections, may result from the impairment(s) itself, medication or other treatment, or chronic illness. These effects can determine whether a child feels well enough and has sufficient energy to engage in age-appropriate activities, either alone or with other children.

In the domain of "Moving about and manipulating objects," we consider how well children can move their own bodies and handle things. We evaluate limitations of fine and gross motor movements caused by musculoskeletal and neurological impairments, by other impairments (including mental disorders) that may result in motor limitations, and by medications or other treatments that cause such limitations.¹⁴

In fact, an impairment(s) may have effects in *both* domains when it affects the child's general physical state and fine or gross motor functioning. For example, some medications used to treat impairments that affect motor functioning may have physical effects

(such as nausea, headaches, allergic reactions, or insomnia) that sap a child's energy or make the child feel ill. We evaluate these generalized, cumulative effects on the child's overall physical functioning in the domain of "Health and physical well-being." We evaluate any limitations in fine or gross motor functioning in the domain of "Moving about and manipulating objects."

Effects in Other Domains

Impairments that affect health and physical well-being can have effects in other domains as well. For example, a child who must frequently miss school because of illness (including the need to go for treatment) may have social limitations that we also evaluate in the domain of "Interacting and relating with others," behavioral manifestations that we evaluate in the domain of "Caring for yourself," or both. In some cases, chronic absence from school may result in limitations we also evaluate in the domain of "Acquiring and using information."

Additionally, generalized or localized pain that results from an impairment(s) may interfere with a child's ability to concentrate, an effect that we evaluate in the domain of "Attending and completing tasks" and often in the domain of "Acquiring and using information." Pain may also cause a child to be less active socially, an effect that we evaluate in the domain of "Interacting and relating with others." Some medications for physical impairments may affect mental functioning, interfering with a child's ability to pay attention, remember, or follow directions. We consider these effects in the domain of "Acquiring and using information," "Attending and completing tasks," or both depending upon the type of limitation that results. Other medications for physical impairments may cause restlessness, agitation, or anxiety that may affect a child's social functioning (which we evaluate in the domain of "Interacting and relating with others") or emotional well-being (which we evaluate in the domain of "Caring for yourself").¹⁵

Therefore, as in any case, we evaluate the effects of a child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is *not* "double-weighting" of either the impairment(s) or its effects. Rather, it

¹⁴ For more information about the domain of "Moving about and manipulating objects," see SSR 09-6p, Title XVI: Determining Childhood Disability: The Functional Equivalence Domain of "Moving About and Manipulating Objects."

¹⁵ Further, a child may also have social difficulties because of a device used for treatment or assistance in functioning, such as the need to use a breathing device or other adaptive equipment, that results in social stigma.

recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.¹⁶

Examples of Limitations in the Domain of "Health and Physical Well-Being"

To assist adjudicators in evaluating a child's impairment-related limitations in the domain of "Health and physical well-being," we provide the following examples of limitations that are drawn from our regulations, training, and case reviews. They are not the only limitations in this domain, nor do they necessarily describe a "marked" or an "extreme" limitation.¹⁷

In addition, as in the examples of limitations for the other five domains, we consider a child's age¹⁸ in determining whether there is a limitation in functioning in the domain of "Health and physical well-being." 20 CFR 416.926a(1)(4). While it is less likely that age will be a factor in determining whether there is a limitation in this domain, it is still possible, and we must consider the expected level of functioning for a given child's age in determining the severity of a limitation.

- Has generalized symptoms caused by an impairment(s) (for example, tiredness due to depression).
- Has somatic complaints related to an impairment(s) (for example, epilepsy).
- Has chronic medication side effects (for example, dizziness).
- Needs frequent treatment or therapy (for example, multiplesurgeries or chemotherapy).
- Experiences periodic exacerbations (for example, pain crises in sickle cell anemia).
- Needs intensive medical care as a result of being medically fragile.

DATES: *Effective date:* This SSR is effective on March 19, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; SSR 09–2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Acquiring and Using Information"; SSR 09–4p, Title

XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Interacting and Relating with Others"; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Moving About and Manipulating Objects"; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Caring for Yourself"; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–1p.]

Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–1p. This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about our "whole child" approach for determining whether a child's impairment(s) functionally equals the listings.

DATES: *Effective Date:* March 19, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Bendann, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–9118.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration.

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated:

February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach

Purpose: This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about our "whole child" approach for determining whether a child's impairment(s) functionally equals the listings.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ who applies for Supplemental Security Income (SSI)² is "disabled" if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments³ that results in "marked and severe functional limitations."⁴ 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of

¹ The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any "individual" who has not attained age 18. In this SSR, we use the word "child" to refer to any such person, regardless of whether the person is considered a "child" for purposes of the SSI program under section 1614(c) of the Act.

² For simplicity we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

³ We use the term "impairment(s)" in this SSR to refer to an "impairment or a combination of impairments."

⁴ The impairment(s) must also satisfy the duration requirement in section 1641(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

¹⁶ For more information about how we rate limitations, including their interactive and cumulative effects, see SSR 09–1p.

¹⁷ There are some rules for determining whether there is a "marked" or an "extreme" limitation in the "Health and physical well-being" domain that are unique to this domain. See 20 CFR 416.926a(e)(2)(iv) and 416.926a(e)(3)(iv).

¹⁸ See 20 CFR 416.924b.