How Do I Satisfy the Social Security Disability Medical Listing 12.15 for PTSD?

In 2017 the Social Security Administration created a new disability listing for trauma- and stressor-related disorders The listing 12.15, first requires medical documentation of all five of the following:

- exposure to actual or threatened death, serious injury, or violence
- subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks)
- avoidance of external reminders of the event
- disturbance in mood and behavior, and
- increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

Once a diagnosis of PTSD is made by a psychologist or psychiatrist under the above criteria, Social Security then determines if the applicant has the required level of functional limitations due to post-traumatic stress. An applicant, much as in the other 120.1-12.16 psychological domains must have either an "**extreme"** limitation in one of the following areas or a **"marked"** limitation in two of the following areas:

- understanding, remembering, or using information (learning new things, applying new knowledge to tasks, following instructions)
- interacting with others in socially appropriate ways
- being able to concentrate on tasks in order to complete them at a reasonable pace
- adapting or managing oneself (regulating one's emotions, adapting to changes, having practical personal skills like paying bills, shopping, hygiene).

Some applicants won't be experiencing the functional limitations above at the level necessary to satisfy the listing because they live in highly protected and supervised situations or they are undergoing intense therapy that makes their functional abilities appear better than would be the case in real-life situations where the stress and demands on them would be greater. In other words, their condition is less than marked or severe. In these cases, there must be documentation that the applicant's PTSD has been serious and persistent over a period of at least two years and that the applicant has minimal capacity to adapt to changes or the demands of work.

In these sorts of cases We send our clients out with the Residual Functional Capacity Questionnaire that appears below. Feel free to download it from our site www.disabilityattorney.net to use in your case if you wish. Please remember though that the use of this form signed by your treating psychiatrist or Psychologist (PhD, PsyD, DO or MD) does not mean that you will automatically win your case. The completed form in the hands of a skilled disability attorney will increase your chances of winning though. So have the form completed and have it reviewed by a qualified disability attorney who can review your record and help you develop your testimony so you can win your case.

PTSD: 12.15 TRAUMA & STRESS RELATED DISORDERS & MENTAL RESIDUAL FUNCTIONAL CAPACITY QUESTIONAIRE

Patient: _____ SS#: _____

A. **Nature frequency or length of contact**: _____.

1. a. Summary of records or documents reviewed: _____ .

b. Assessment is: from: _____ to: _____

c. **Specify applicable diagnoses, (check appropriate category (ies) upon which the medical disposition is based**.

___ 1. 12.02 Organic Mental Disorders, ___ 2. 12.03 Schizophrenic, Paranoid and Other Psychotic Disorder, ___ 3. 12.04 Affective Disorders, ___ 4. 12.05 Mental Retardation ___5. 12.06 Anxiety-Related Disorders, ___6. 12.07 Somatoform Disorders ___7. 12.08 Personality Disorders ___ 8. 12.09 Substance Addiction Disorders ___ 9. 12.10 Autism and Other Pervasive Developmental Disorders, ___ 10. 12.11 Neurodevelopmental disorders, ___ 11. 12.13 Eating Disorders, ___ 12. 12.15 Trauma and stressor – related disorders.

2. DSM-IV Multiaxial Evaluation:

Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: _____

Current GAF: _____ Highest GAF this past Year: _____

3. Treatment and response:
_____.

4. Describe side effects of medication w/ implications for working: ___ excessive sleep, ___ drowsiness, ___ fatigue, ___ decreased ability to concentrate: (other)
_____.

5. Describe *clinical findings* including results of IQ or mental status examination that demonstrate the severity of the claimant's mental impairment and symptoms:
_____.

6. Prognosis:
_____
_____.

7. Identify patient's signs and symptoms:_____.

8. Patient: ____ does ____ does not : have a low IQ or reduced intellectual functioning.

a. The patient's IQ can reasonably be estimated to be: ____ 69 and below ____ 70-84, ___ 85 and above. Please explain (w/re to specific test results if possible):
_____
_____
_____.

9. Does the psychiatric condition exacerbate the claimant's experience of pain or any other physical symptom/s? _____
Yes No If yes, please explain:_____.

10. The claimant's mental condition ___ has ___ has not lasted or can it be expected to last at least 12 months.

11. The claimant's impairments ___ are ___ are not reasonably consistent with the symptoms and functional limitations described in this Evaluation and clinical presentation.

13. Is the use of illicit drugs or alcohol a major contributing factor to patient's mental impairment? ____ yes ____ no

B. Criteria of the Listings

The following is an indication as to what degree the following functional limitations (which are found in 12.00 and 12.15 and paragraph B of listings 12.02-12.04, 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s). The following definitions apply: "**Mild**" is defined as affecting the claimant between 1% to 5% of an 8 hour work-day, "**Moderate**" between 6% and 33%, "**Marked**", between 34% and 66%, "**Extreme**", 67% or more of an 8 hour day.

12.15: For PTSD and/or Other Stress Related Disorders:

1. a. Does the claimant have a history or symptoms of any or all of the following? Please check any and all that apply: ___ Exposure to actual or threatened death, serious injury, or violence; ___ Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks); ___ Avoidance of external reminders of the event; ___ Disturbance in mood and behavior; and ___ Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

2. a. Does the claimant have a history or symptoms of extreme limitation of one, or marked limitation of two, of the following areas of mental functioning? Please check any and all that apply:
___1. Ability to understand, remember, or apply information (see 12.00E1). __ extreme limitation or __ marked limitation
___2. Ability to interact with others (see 12.00E2). __ extreme limitation, or __ marked limitation
___3. Ability to concentrate, persist, or maintain pace (see 12.00E3). __ extreme limitation, or ___marked limitation
___4. Ability to adapt or manage oneself (see 12.00E4). __ extreme limitation, or ___ marked limitation

3. a. Is the patient's mental disorder in this listing category "serious and persistent;" that is, does he or she have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both: 1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and 2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c). ___ yes ___ no

4. a. For mental Impairments inclusive of 12.02-12.15 please provide your opinion as to the patient's other mental limitations, including ADL (Activities of Daily Life)not already addressed above.

FUNCTIONAL LIMITATION **DEGREE OF LIMITATION**

1. Restriction of ADL __ None __ Mild __ Moderate __ Marked* __ Extreme* __ Insufficient Evidence
2. Difficulties in Maintaining
   Social Functioning: __ None __ Mild __ Moderate __ Marked* __ Extreme* __ Insufficient Evidence
3. Difficulties in Maintaining Concentration, Persistence or pace required to perform simple, routine repetitive
   Tasks: __ None __ Mild __ Moderate __ Marked* __ Extreme* __ Insufficient Evidence
4. Repeated Episodes of Decompensation, each of 1 week or more resulting in patient's inability to engage in
   Full-time regular employment: __ None __ Mild __ Moderate __ Marked* __ Extreme* __ Insufficient Evidence

C. **Criteria of the Listings**

1. **Please complete this section & check the appropriate box as apply to the patient:**

Medically documented history of a chronic **organic mental** (12.02), **schizophrenic**, etc. (12.03), or **affective disorder** (12.04) of at least 2 years duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, **and one of the following:**

__ Repeated episodes of decompensation, each of extended duration __ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate

__ Current history of 1 or more years inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement

__ Complete inability to function independently outside the area of one's home

D. **Concentration and Attendance**

Regarding the following question, "**Rarely**" means 1%-5%, "**Occasionally**" means 6%-33%, "**Frequently**" means 34%-66%, "**Constantly**" means over 66% of an 8-hour working day. With those descriptions in mind, please answer the following question.

1. How often during a potential 8 hour work day would the patient be reasonably expected to experience psychiatric symptoms or the effects from prescribed medication that severe enough to interfere with attention and concentration needed to perform even simple routine repetitive tasks?

   ___ Never ___ Rarely ___ Occasionally ___ Frequently ___ Constantly

2. On the average, it is reasonably anticipated to anticipate that the claimant's psychiatric impairments, medications or treatment would cause the claimant to be absent from work as follows:

   __ Never __ 1 day/month month __ About 2 days/month __ About 3 days/month

   __ About 4 days per month __ More than 4 days per month

3. Additional reasons not covered above why the claimant would have difficulty working at a regular job on a sustained basis not covered above: _____.

4. Any additional comments:

   _____

   _____

   _____

   _____

   _____

5. If applicable, t**he earliest date prior to the date of completion of this questionnaire that the description of the symptoms and limitations in this questionnaire applies is: _____**

Date evaluation completed: _____

_____

Physician's Signature

_____

Printed or typed name of physician
(Or, attach business card here)
Date Form Completed: _____