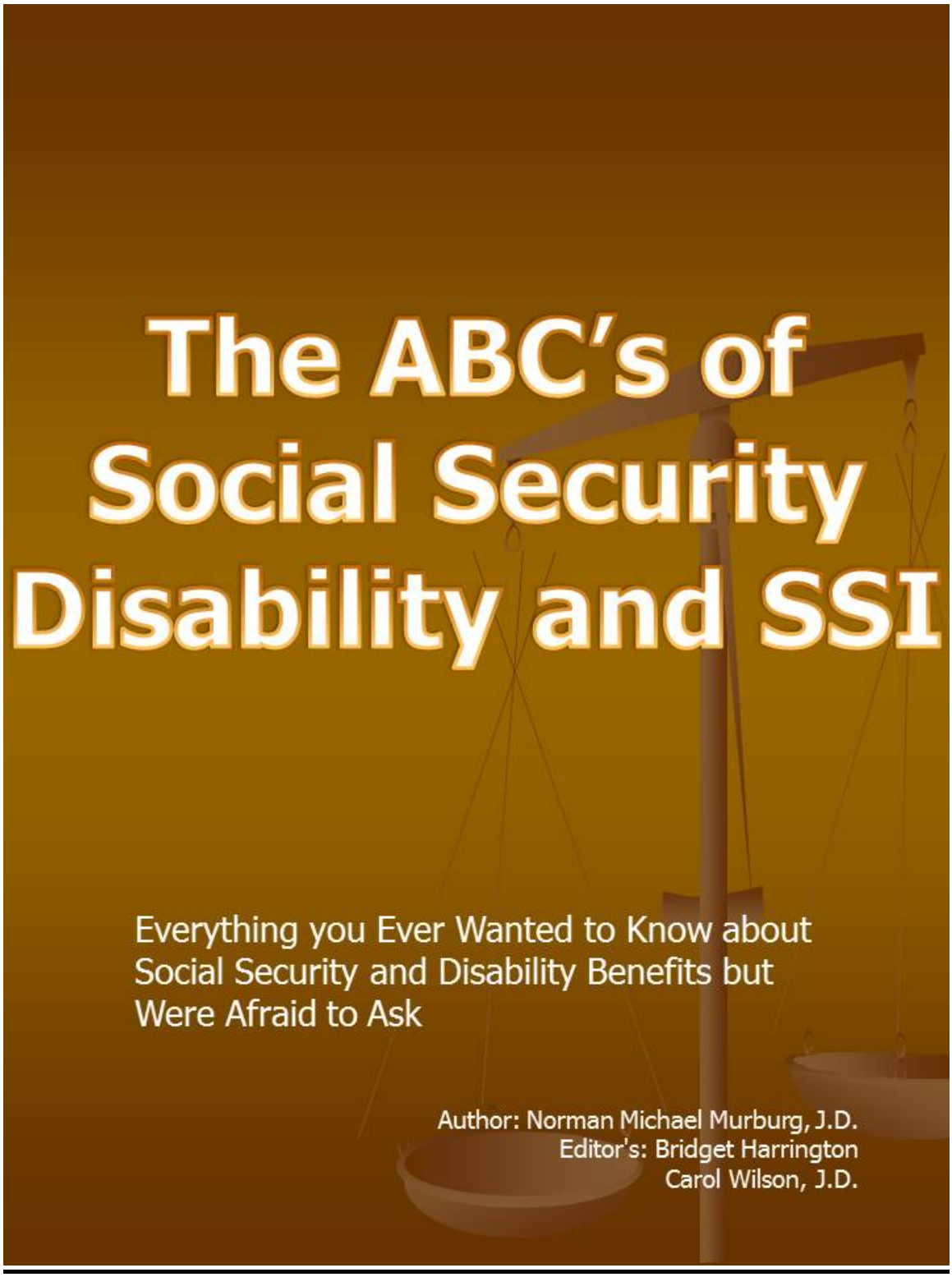
The ABC's of Social Security Disability and SSI
Everything you Ever Wanted to Know about Social Security and Disability Benefits but Were Afraid to Ask
Author: Norman Michael Murburg, J.D.
Editor's: Bridget Harrington
Carol Wilson, J.D.

# THE CLAIMANT'S SOCIAL SECURITY DISABILITY, V.A AND RELATED BENEFITS

**or "Everything You Ever Wanted to Know about Social Security and VA Disability Benefits but Were Afraid to Ask"**

## By Mike Murburg

**ABOUT THE AUTHOR**

**Mike Murburg**

Mike has been admitted to practice law in Florida, Washington State, Court of Appeals for Veterans' Claims, Federal Courts for the Middle District of Florida and the 11th Circuit Court of Appeals and before the United States Supreme Court. He is a member of the Hillsborough, Pinellas and Pasco County Bar Associations and is a member in good standing with the National Organizations for Social Security Claimants' and Veterans' Representatives.

N. Michael Murburg, Jr., “Mike” was an academic scholarship recipient and graduated from Princeton University in 1977. While there, Mike majored in history and lettered in both football & wrestling. Mike led his wrestling team to two consecutive Ivy League Championships and went to the NCAA Wrestling Championships in 1975. After a brief stint on Wall Street, Mike left to teach. In 1979, Mike moved to the Tampa Bay area where he taught and coached football teams at Clearwater and Tarpon Springs High Schools, winning two county championships before entering law school in 1983. In 1986, Mike graduated from Florida State University, College of Law Cum Laude (with honors) and helped found the law school’s highly successful mock trial team. During that time Mike also worked full time to support his new family as a law clerk to the Florida Bar in their ethics division and also worked as an adjunct volunteer to North Florida Legal Services where he first became exposed to the needs of the disabled and their families.

After graduating from law school, Mike served between 1986 and 1990 as an Assistant State Attorney for the Sixth Judicial Circuit in Pasco and Pinellas Counties, where he was responsible for the prosecution of over 7,000 criminal cases, ranging from minor crimes to homicides. During that time, Mike developed his trial skills and led his office to place second in the State of Florida for a percentage of successful prosecutions in his last two years as an Assistant State Attorney. Mike has personally litigated to verdict over 90 civil and criminal trials with a success rate of nearly ninety percent. He has personally handled and litigated to conclusion over 1,500 Social Security Disability claims and has maintained a success rate annually of over 95%.

In 1990, Mike left the office of the State Attorney to work as a lead trial counsel for the St. Petersburg, Florida law firm of Yanchuck, Thompson, Young and Breman, P.A., where he was the firm’s lead trial counsel and practiced in the areas of plaintiff’s personal injury, medical malpractice, workers’ compensation and social security disability. During this time, Mike also served as an appointee to the Board of Directors to the Bay Area Legal Services.

In 1992, Mike began his own law firm, Mike Murburg, P.A. Originally the firm had one office in New Port Ritchey, Florida. As his practice expanded and his firm grew, Mike opened six additional offices to serve clients throughout the greater Tampa Bay area. Mike now routinely practices before the Administrative Law Judges in the Tampa, Orlando and Ocala areas as well as in other such Courts from as far south as Puerto Rico to as far north as Maine and along the East Coast, and as far west as Indianapolis, Las Vegas, Spokane, Phoenix and in cities like New York, Philadelphia, Boston and Chicago.

Mike’s popularity and the growth of his firm reflect both his ability and his “down to earth” attitude, as well as a dedication to professional excellence. Mike’s history of assisting the disabled and helping the injured are reflected not only in his long history of public service but in his pro-bono work for the indigent and the poor. However Mike’s life has not been as easy as one might think.

In 1996, Mike was diagnosed with Meniere's disease, a potentially disabling condition which almost caused Mike to be unable to work. The condition forced Mike to have to look realistically at the prospects of being a single parent of two small children and having to file for disability. Fortunately, Mike overcame the disease, but his awareness of the fear of what it means to be disabled never left. In 1996, Mike intentionally began to reduce hic civil trial caseload and to expand his disability practice so as to help as many clients as he could, hence the creation of Disabilityattorney.net and this website. This dedication was only renewed when he was diagnosed with cancer in 2005. In 2005 Mike, so as to insure that his clients would have access to only the best and the brightest lawyers to handle their cases, made Carol Wilson, a partner in the law firm. Mike is now cancer free and is a multiple year survivor and the prognosis for both him and his ability to serve his clients remains excellent. Mike is not one to quit fighting either for his clients or for himself, and he is honored and privileged to do the work he does for them. For Mike, "Doing the work I do for the disabled is more a calling than a livelihood. It is what gets me up in the morning. I have never had more meaningful work and do not expect that I ever will. These people need help, and we will help as many as we professionally and possibly can. I think that other than laying down one's life for his fellow man, there is perhaps, no more noble a calling."

At the Law offices of Mike Murburg, P.A., we handle Social Security Disability and SSI cases from initial consultation through trial and in all related appeals. In all of our cases consultations are always free. No fees or costs are ever due up front to retain us. We also handle our clients' serious injury, wrongful death, and related disability matters.

The Firm of Mike Murburg, P.A. is dedicated to the zealous representation of its clients within the bounds of professional ethics and the law. It is the mission of the firm to personally and responsibly represent the disabled, pursue their rights, and obtain the fullest amount of compensation that the law will allow.

## Practice Areas

Social Security Disability (SSDI), SSI, Long Term Disability, Railroad Retirement Board Disability, Veterans' Disability & Injury Law

# INTRODUCTION

This book is written for both the person who wants to reasonably try to take on the filing and prosecution of their own Social Security Disability claim or VA disability claim by themselves. It is also written for the attorney or certified non-attorney representative who are considering the representation of persons for the first time in pursuing a client's Social Security or Veteran's disability claim. It is also written for attorneys' or representative's staff who may want a refresher course on what it all means and how to get the nuts and bolts of the process down.

The book, in its more basic form was first written as a means of educating our clients at our Law Offices, The Law Offices of Mike Murburg, P.A. and posted on our website at disabilityattorney.net. The revisions have been posted and can be found on that website which our readers are free to use at any time.

This book, by its nature, cannot be all-inclusive of all forms of disability. This book and related websites are not meant or intended to give legal advice or to substitute for the advice of that which otherwise would be given within an attorney-client relationship. Though written by licensed practicing attorneys whose primary of area of practice is social security disability and its related fields, this book and related websites are for informational use and educational purposes only. They are not meant or intended to replace or supplant advice given or expected to be given by an attorney. That being said, I have included some fundamental information about private disability insurance benefits and how they dovetail with Social Security and some useful forms at the end of this book. These forms may help the reader obtain valuable medical information from their physicians that may be useful in the success of the reader's claim.

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55. **If, after careful consideration of the record, the judge finds that a claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) and 416.967(a) with lifting no more that 10 pounds occasionally and can stand/walk no more than 2 hours in an eight hour day, and sit for less than two hours of an eight hour day, would that person be disabled?**
56. **If, after careful consideration of the record, the judge finds that a claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) and 416.967(a) with lifting no more that 10 pounds occasionally and can stand/walk no more than 2 hours in an eight hour day, and sit up to six hours of an eight hour day, would that person be disabled?**
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64. **Does a claimant's pain really matter in a disability case?**
65. **Must a judge sufficiently articulate the reasons for assigning treating physicians opinions little or no weight and relying instead on parts of the**

**opinion of a non-examining medical consultant that had not examined the claimant or considered the record as a whole?**

**66. Will a claimant's own physician's opinions that are consistent with the claimant's treatment record be given controlling weight in his or her disability case?**

**67. Must an ALJ develop a full and fair record and take into account the claimant's medical history, absenteeism, and pain in assessing a claimant's residual functional capacity?**

**68. Must an ALJ consider ALL of a claimant's limitations?**

**69. Must an ALJ consider or address the side effects of a claimant's medications on his or her employability?**

**70. What if the ALJ fails to consider the claimant's need for medical care and treatment that will occur on a regular basis, or the absences he or she will probably have for this medical care or just being too sick to work a few days or more per month due to sickness?**

**71. What is the claimant's burden to prove in his or her disability case?**

**72. What if a claimant's pain or depression prevents a claimant from concentrating on simple one or two step tasks throughout the day, is that something the ALJ has to consider if a claimant testifies about it or his or her doctors have written about this and those reports are in the record?**

**73. If a claimant suffers from obesity and it is not his or her primary disabling condition, must the ALJ consider the effects of obesity on residual physical capacity in determining if the claimant is disabled or not?**

**72. Once a claimant meets the burden, does the burden shift to the government and how does the SSA go about showing that a claimant is not disabled?**

**74. What if a claimant has fibromyalgia; what must a judge or physician find if he or she is to be eligible for SSI or Disability benefits?**

**75. What is the American College of Rheumatology's definition of fibromyalgia?**

**76. Are "environmental restrictions" important to a disability case?**

**77. What if a claimant has Chron's Disease, IBS, and/or Colitis? What are the legal or medical considerations that a treating physician should document to help the patient's case?**

**78.a. Can a minor be considered medically disabled?**

**78.b. Are a disabled child's SSI benefits payable prior to the date his or her application is filed?**

**78.c. Under what authority can an ALJ find a child disabled?**

**78.d. What are the steps of analyses involved in determining whether a child is disabled?**

**79.e. What is step two in determining whether a child is disabled?**

**79.f. What does step three entail?**

**79.g. What must the ALJ consider?**

**79.h. What is the purpose of determining the "Six Domains" and functionally equaling a listing?**

**79.i. What does an ALJ have to do to make this assessment?**

**79.j. What else does an ALJ have to consider?**

**79.k. What do you mean by a child's "marked" limitation?**
**80. What is an "extreme" limitation?**
**80.a. What must an ALJ do to determine the degree of limitations in each of the "six functional domains"?**
**81.a. What is the first of the six "functional domains"?**
**81.b. What is the second of the six "functional domains"?**
**81.c. What is the third of the six "functional domains"?**
**81.d. What is the fourth of the six "functional domains"?**
**81.e. What is the fifth of the six "functional domains"?**
**81.f. What is the last of the six "functional domains"?**
**81.g. If a child has only one "marked" limitation and no "severe" ones, can she be found to be disabled?**
**81.h. When does a claimant become eligible for Medicaid or Medicare if he or she is disabled?**
**81.i. In Florida, if a person is disabled and a Medicare recipient, can a physician legally charge him or her more than Medicare will allow?**
**81.j. How can a physician go about legally charging more than Medicare will pay?**

## FLORIDA LAW

**82. So, if a disabled person is in an accident, what should the physician do?**
**83. Does Florida law define me as a Medicare recipient?**
**84. If a Florida Medicare recipient becomes an injured party, and is a Medicare Beneficiary, who is liable for damages including the amounts that treating physicians charged under contract/letters of protection?**

**85. So, how would this work out in an accident case involving a Medicare beneficiary?**
**86. How do courts limit these recoveries from physicians in Florida?**

## RESIDUAL FUNCTIONAL CAPACITY FORMS LIST

## PRIVATE LONG TERM DISABILITY CASES: F.A.Q.S.

**1. If I am receiving Long Term Disability Insurance benefits from an insurer, how will Social Security disability benefits affect my Long Term Disability benefits?**
**2. If I am receiving Long Term Disability benefits, how do I apply for Social Security benefits?**
**3. If I have been found to be disabled by my Long Term Disability Carrier, what are my chances of receiving Social Security benefits?**
**4. Should I send Social Security a copy of the LTD Carrier's medical evaluation and my treating physician's monthly disability statements?**
**5. Do I need to hire a lawyer to help me through the LTD application process?**

**5.a. Whom should I contact if I am disabled and have been a Florida county or state employee?**
**5.b. What will I need to file?**

## "COBRA" and ERISA COVERAGE F.A.Q.S.

1. **What is "Cobra" coverage?**
2. **If I am employed and get health insurance coverage through my employer and it stops, what is continuation coverage?**
3. **How long will continuation coverage last?**
4. **When will continuation coverage will be terminated before the end of the maximum period?**
5. **How can you extend the length of continuation coverage? (If your maximum is less than 33 months).**
6. **Will applying or receiving Social Security Disability affect my COBRA coverage?**
7. **What is a "Second Qualifying Event"?**
8. **How can I elect continuation coverage?**
9. **How much does continuation coverage cost?**
10. **When and how must payment for COBRA continuation coverage be made?**
11. **Are there any grace periods for periodic payments?**
12. **Is there more information available on continuation coverage or other rights I may have?**
13. **Do I need to keep my plan administrator?**
14. **Will I receive notice of my right to continue my health care coverage after employment is terminated?**
15. **What will my election form look like and what will it require of me?**

## FREQUENTLY ASKED QUESTIONS, FLORIDA WORKERS' COMPENSATION DISABILITY

1. **What is the purpose of Workers' Compensation?**
2. **What is an "accident" within the meaning of Florida's Workers Compensation Law?**
3. **Whom is covered by Florida's Workers Compensation Act?**
4. **What if I get injured and my boss doesn't have Workers' Compensation coverage?**
5. **My doctor has told me that I will be at "maximum medical improvement" (or "MMI") soon. What does that mean?**
6. **I have heard that my doctor says that my injury was not the major contributing cause of my problems. What is "major contributing cause" mean?**
7. **When is compensation payable for my lost wages and medical bills?**

8. **What if I am injured in a motor vehicle accident while I'm on the job? What can I do?**
9. **If I am in an accident while at work what do I do?**
10. **What if I am injured and I fail to advise my employer of the injury within 30 days after the initial manifestation of the injury?**
11. **What if I report my injury to my boss and he does not report the injury to the Workers' Compensation carrier?**
12. **What if I'm in a motor vehicle accident? What insurance applies?**
13. **When does the Workers' Compensation carrier have to pay me for my lost work?**
14. **How are my medical fees paid?**
15. **What is a "Workers' Compensation Managed Care Arrangement"?**
16. **If I am injured, to what compensation am I entitled?**
17. **How long do permanent total disability benefits last?**
18. **What if I'm not permanently totally disabled, just temporarily disabled? To what benefits am I entitled?**
19. **What if I am disabled for more than 104 weeks?**
20. **What if I am able to go back to work but I can't work as much as I had due to my injury?**
21. **Am I entitled to Permanent Impairment Benefits if I am not Totally Disabled?**
22. **Am I eligible for benefits under the Workers' Compensation Act if I receive benefits under unemployment compensation?**
23. **What if I get into a benefit dispute with my Workers' Compensation carrier? What do I do?**
24. **If I file my own petition will I be liable for costs?**
25. **If I hire an attorney can I expect not to have the other side to pay my attorney's fees?**
26. **If I am in debt and I assign my claim to a creditor is it a valid assignment?**
27. **If I file a petition do I have to go to mediation?**
28. **If there was an impasse at mediation when will my hearing be concluded?**
29. **If I think that I am permanently totally disabled can a Judge adjudicate me as such without the employer and Workers' Compensation carrier being given the opportunity to assess me for the purpose of reemployment?**
30. **If I am involved in an automobile accident within the scope of my employment, what should I do and what laws govern?**
31. **Who can handle such a lawsuit or claims or a complicated settlement of an on-the-job accident or injury involving motor vehicles or product liability issues?**
32. **Should I settle my Workers' Compensation case without using an attorney?**

## PERSONAL INJURY F.A.Q.S. (Florida Personal Injury and Motor Vehicle Law)

1. **What should I do if I am in an automobile accident?**
2. **Who will pay my medical bills and lost wages?**
3. **If I am on Medicare or Medicaid, shouldn't they pay my bills?**
4. **How and when should my case be concluded?**
5. **What should I tell my doctors?**
6. **With whom must I communicate about my accident?**
7. **What is a "Letter of Protection" and how will it affect my case?**
8. **If I am injured, am I entitled to a financial recovery, even though I was not at fault?**
9. **When should my lawsuit be filed?**
10. **If a lawsuit is filed, I have heard that I must attend and give a "deposition". Exactly what is that and how should I prepare for it?**
11. **I have read that 90% of lawsuits filed are settled in "Mediation."**
12. **What is a Mediation?**
13. **Why is a case mediated?**
14. **Who are the mediators?**
15. **How are mediators compensated?**
16. **What are the advantages of mediation?**
17. **Will my statements at mediation be confidential?**
18. **What does a mediator report to the Court?**
19. **What if I am injured in a "Slip and Fall" Accident?**
20. **If I am injured in a slip and fall who will pay for my bills?**
21. **In Florida, if I am disabled and a Medicare recipient, can a physician legally charge me more than Medicare will allow?**
22. **So, if I am in an accident, what should I do?**
23. **Does Florida law define me as a Medicare recipient?**
24. **How can a physician go about legally charging me more than Medicare will pay?**
25. **So, how would this work out in an accident case involving a Medicare Beneficiary?**
26. **How do courts limit these recoveries from physicians in Florida?**
27. **If I have been injured in a motor vehicle accident, will you evaluate my case and contact me?**

## V.A. FREQUENTLY ASKED QUESTIONS AND ANSWERS

1. **What are Service Connected Veteran's Disability benefits?**
2. **Does the award of these benefits depend on my income or assets?**
3. **Can I collect both Service connected VA Disability and Social Security Disability?**
4. **Isn't this "Double Dipping"?**
5. **If I file for Social Security disability, will it help in my VA case and visa-versa?**
6. **Are there other types of VA Benefit Claims that Mike Murburg, P.A. handles?**

7. **What do I need to have in order to make a claim for VA Disability Benefits?**
8. **When does this condition need to begin?**
9. **What about conditions that I notice that have developed after I have left the Service?**
10. **What is a "Presumptive Service Connection"?**
11. **What must I show to get these VA Disability Service Connected benefits?**
12. **What if I am injured in a VA facility or program?**
13. **What is a "Ratings Schedule"?**
14. **What do you mean? I have a bad back and I have trouble bending and walking. How would they try to rate me?**
15. **Is "functional loss" considered?**
16. **What if I have two evaluations and one is more restrictive than the other?**
17. **Do you have any suggestions about preparing for my VA range of motion tests?**
18. **Do you have any other hints or suggestions?**
19. **Is the VA rating dependent on my condition getting better or worse?**
20. **How is my "Total Disability Rating" determined?**
21. **When is "total disability" presumed to exist?**
22. **Well, I understand if my rating is 100% how I might get a full VA Service connected disability. But how about if my disabilities add up to something less and I still cannot work. What then? Am I out of luck?**
23. **What is a rating based on "Unemployability" (TDRU)?**
24. **What is the norm for finding total disability based on unemployability outside of the traditional ratings schedule?**
25. **Ok, so what if I am not 100 percent and I still cannot work. What will the VA look at to see if I am entitled to a full award of disability compensation?**
26. **What if I do not have a single 60%. Can I still get the full amount based on unemployability?**
27. **What if I don't have one 40% rating? Can I still get a full disability award?**
28. **What about if I parachuted, fell or was injured by an explosive device that injured my back, but also affected my sight or arms or legs? Shouldn't I be eligible for the 40%?**
29. **What about other body organs; are they also grouped?**
30. **What about where I injured numerous body parts and mechanisms in action?**
31. **Are these standards ever set aside for special cases?**
32. **Can you give me an example?**
33. **What if they say my case is not entitled to such a review?**
34. **What if my Statement of the Case is silent on this point?**
35. **What if I work for my family because nobody else will hire me because of my service connected disabilities? Is that "Substantial Gainful Employment"?**
36. **What do you mean by "Marginal"?**
37. **Is the reason for my leaving employment or termination relevant to my VA claim?**
38. **What if I were working in a "Special Program"?**

39. **When should I file my claim?**
40. **Who is responsible for filing information to support my claim for benefits?**
41. **If my claim is denied, when should I file my appeal?**
42. **What if I don't file my appeal within the requisite deadlines?**
43. **What are my rights to appeal a VA decision?**
44. **What is an Appeal to the Board of Veterans' Appeals, (BVA Appeal)?**
45. **How can I appeal the decision and how do I start my appeal?**
46. **When do I file the Notice of Disagreement?**
47. **What happens after the VA receives my Notice of Disagreement (NOD)?**
48. **What is a VA Form 9?**
49. **That sounds complicated. What do I have to write in my VA Form 9 so that my appeal is accepted?**
50. **How long do I have to start my BVA Appeal?**
51. **So is timing important?**
52. **What does a "Supplemental Statement of the Case" do to my time to appeal?**
53. **How does the VA determine that my appeal has been timely filed?**
54. **Do I just send my appeal First Class Mail?**
    **What happens if I do not start my appeal on time?**
56. **Can I get a hearing with the Board?**
57. **Where can I find out more about appealing to the Board?**
58. **What if I am denied my benefits? Can I get someone to help me with my appeal to the Board?**
59. **Do I have to pay someone to help me with my appeal to the Board?**
60. **Can I get someone to represent me for free?**
61. **Should I hire an attorney?**
62. **Can or should I give VA additional evidence?**
63. **When should I give the VA my evidence?**
64. **What if I choose to present new evidence?**
66. **Is the VA hearing separate from my Board (BVA) hearing?**
67. **What happens after I give VA evidence?**
68. **When will my VA check be delivered?**
69. **What if I get a VA pension because most of my disability was not service connected and my service connected disability increases, can I go from pension to Service connected total disability?**
70. **How can I receive additional benefits for dependents?**
71. **How can I receive aid and attendance or housebound benefits?**
72. **How can I receive Hospitalization and Outpatient Treatment?**
73. **How can certain expanses increase my rate of improved pension?**
74. **How can I receive information about Government Life Insurance?**
75. **Are my benefits exempt from claims of creditors?**
76. **Do I report a change of address?**
77. **What conditions affect my right to payment?**
78. **If I am receiving VA Disability, should I let my attorney know and give him a copy of my VA Award notice before my case is set or soon after my case is set for hearing?**

79. **If I am a Disability Claimant, as a Veteran who has applied for Social Security Disability or SSI Benefits, must my VA Doctor assist that claimant in completing paperwork helpful to my Social Security Disability or SSI case?**
80. **If I have more questions concerning VA Awards, where can I find out more information?**

# FREQUENTLY ASKED QUESTIONS

## SOCIAL SECURITY, SOME BASIC QUESTIONS

**1. What is Social Security Disability?**

If you are an American or documented worker who has worked in this country for at least 5 of the last 10 years, the deductions made for your Social Security taxes have been placed into a fund for you to be paid to you as a monthly income should you become disabled according to the social Security Administration Guidelines.

**2. Who is eligible for Social Security Disability (SSD)?**

If you are under the age of 65 and are disabled and have sufficient earning credits as determined by the Social Security Administration (SSA) you are entitled to Social Security Disability Income (SSDI) benefits. If you do not have enough credits to qualify for SSDI you may still qualify for Supplemental Security Income (SSI) benefits. The amount of your SSI payments will depend on the household income and assets.

**3. How can I tell if I am disabled?**

One can be found disabled medically or vocationally based on age, education and past work history. Medically, one is evaluated under the Social Security guidelines found in their guides to Disability Evaluation found at www.socialsecurity.gov. One can also be found disabled for approximately seventy five or more separate severe conditions found under compassionate allowances/conditions found on the Social Security Website.

Vocationally, as workers age, it becomes easier to be found disabled. If you are 45 and you cannot do any job you have done in the past 15 years and have a severe mental or physical impairment that keeps you from doing all but the easiest jobs, you should apply for Social Security Disability (SSDI) and supplemental Security Income (SSI). Younger persons and children are also eligible for benefits. The rules about social security disability are complex, however. The one sure thing that will keep you from getting disability benefits is not applying for benefits or not appealing a denial of benefits.

**4. How Can I tell the Difference between Social Security Disability and Social Security Income?**

| Issue: | SS Disability (SSD) | Supp. Security Income (SSI) |
|---|---|---|
| Disability Standard: | Same for both programs | Same for both programs |
| Source of Payment: | Social Security Trust Fund | General Revenue |
| Amount of payment: | Based on worker's earnings | Federal amount set by Congress plus state supplement, if any, set by state. State Supplement amount may vary according to living arrangement. |
| Payment to Children: | Yes, additional payment based on earnings records to children under age 18 or under age 19 and still in high school. | No increased federal payment for child; but some state SSI supplements add money for children. Otherwise, children may receive welfare, which is not counted as income; i.e., welfare does not reduce SSI benefit amount. |
| Payment to spouse: | Yes, if child in spouse's care is under age 16 or is disabled. There is an income limit for Spouse's payment | No increased federal payment but some state SSI supplements add money for spouse. |
| Earnings requirement: | Fully insured (1 QC for each year after age 21): and disability insured status (20/40 rule) | none |
| Asset limitation: | None | $2,000 individual, $3,000 per Couple |
| Unearned income limit: | None | A small amount is disregarded; the rest is deducted from SSI benefit. |
| Earned income limit: | Same for both programs for claimants; SGA results in step one denial | After individual is receiving benefits, SSI has more liberal rules designed to encourage work. |
| Waiting period: | Five full months from date of onset of disability | SSI: For applications on or after August 11, 1996, payment begins with first of month after all requirements are met. For earlier applications, payment begins with date of application if all requirements are met. |
| Retroactivity of application: | 12 months if all requirements are met | SSI:No retroactivity. |

Time limit for reopening: 4 years 2 years
Payment processing office: Baltimore or regional payment center local office
Payment applies to: Previous month Current month
Payment Date: By birthday except concurrent cases paid on 3rd of month SSI: 1st day of month
Envelope: Brown Blue
Check says: SOC SEC FOR INS. SSI
Attorney's fees: 25 percent of past due benefits withheld for direct payment (subject to statutory cap of $6,000)
Medical coverage: Medicare begins after receipt of 24 months of benefits.
SSI: Medical coverage in most states begins with entitlement to SSI (sometimes 3 months before).
Eligibility of legal aliens: Eligible SSI: Aliens who were lawfully residing in the U.S. on August 22, 1996 are, for the most part, eligible for SSI disability benefits, but those who arrive later are ineligible with limited exceptions.

**5. Can't I just wait or should I apply for Social Security Disability right away?**

No matter what your circumstances, you should apply for Social Security disability benefits immediately. Social Security will pay benefits retroactively for 12 months prior to your filing date. By waiting, you may lose retroactive benefits and delay your entitlement to Medicare. Moreover, even though you have paid into the system, you are not insured forever and eligibility for SSD benefits will evaporate if you are not found to be disabled prior to your date of being last insured (usually 4 to 5 years after you were last gainfully employed). Finally, waiting may make it more difficult to gather the information that you need to support your claim.

**6. How is the initial entitlement for Social Security Disabled Worker's Benefits made?**

You must have the required work credits, and your health problems must:
* Keep you from doing any kind of substantial work (described below), and
* last, or be expected to last for at least 12 months in a row, or result in death.

**7. What is "Substantial Work" and why is it important?**

Generally substantial work is physical or mental work you are paid to do. Work can be substantial even if it is part-time. To decide if your work is substantial, SSA considers the nature of the job duties, the skills and experience you need and to do the job, and how much you actually earn.

Usually, the SSA will find that work is substantial if your gross earnings average $830.00 per month after SSA deducts allowable amounts. This amount is higher for Social Security disability benefits due to blindness

Your work may be different than before your health problem began. It may not be as hard to do and your pay may be less. However, SSA may still find that your work is substantial under their rules.

If you are self-employed, we consider the kind and value of your work, including your part in the management of the business, as well as your income, to decide if your work

**8. If I qualify for SSDI to how much am I entitled?**

Amounts vary but you may be eligible to receive between $650.00 per month to $2,000.00 per month from the Social Security Administration and perhaps more depending on what you have paid into the system and the number of legal dependents living in your home. In December 2002, the Social Security Administration stated that the average monthly benefit for disabled workers in Florida is $838.00 and $246.00 for dependents of disabled workers. This amount has been subject to yearly COLA amounts and has increased ever since.

**9. If I am found to be disabled, will I be eligible for Medicare or Medicaid?**

If you are accepted as disabled by the Social Security Administration (SSA) you will be eligible for Medicare. If you are disabled and under the age of 65, your medical bills are covered by the state Medicaid program for the first two years after you become disabled. During this time you may select coverage under an approved Medicaid HMO to reduce co-pays or out-of-pocket expenses. Your minor children and dependents may also be entitled to Medicaid coverage after you are determined disabled. Medicaid, to some degree, is income dependent. So there are limitations to eligibility. This is not true with Medicare however.

**10. If I am disabled, how will Social Security and Medicare help me?**

Social Security pays retirement, disability, family and survivors benefits. Medicare, a separate program run by the Centers for Medicare & Medicaid Services, helps pay for inpatient hospital care, nursing care, doctor's fees, drugs, and other medical services and supplies for people age 65 and older, as well as to people who have been receiving Social

Security disability benefits for two years or more. Medicaid a State run federally funded program will supplement and pay for your medical case if you are disabled for your first two years of disability. Medicare does not pay for long-term care, so you may want to consider options for private insurance. Your Social Security covered earnings qualify you for both programs. For more information about Medicare, visit www.medicare.gov or call 1-800-633-4227 (TTY 1-877-486-2048) if you are deaf or hard of hearing.

**11. If I decide to file for SSDI, will Social Security disability insurance help my dependents?**

Yes. If you are approved for SSDI benefits, other family members may also qualify for benefits.
Generally, benefits will be available for:
• Children under 19 who have not finished high school
• A spouse who is caring for a child under the age of 16
• A spouse over age 62
To avoid unnecessary delays, apply for SSDI dependent benefits at the same time you are applying for your own benefits.

**12. Can a non-citizen receive Supplemental Security Income benefits?**

A non-citizen may receive Supplementary Security Income (SSI) if he or she meets the requirements of the laws for non-citizens that went into effect on August 22, 1996 and all the other requirements for SSI eligibility, such as the limits on income and resources. In general, beginning August 22, 1996, most non-citizens must meet 2 requirements to be potentially eligible for SSI:

1. Be in a "qualified alien" category and 2. Meet a condition that allows qualified aliens to get SSI.

There are 8 categories of "qualified aliens". The categories are:
1. Lawfully admitted for permanent resident in the U.S. ("LAPR"), including certain "Amerasian immigrants".2. "Conditional Entrants" under the law in effect before April 1, 1980; 3. Paroled into the U.S. for certain reasons for a period of one year or more; 4. Refugee; 5. Granted asylum; 6. Deportation or removal is being withheld for certain reasons; 7. Cuban and Haitian entrant under the Refugee Education and Assistance Act of 1980; or 8. One of certain aliens who have been subjected to battery or extreme cruelty or whose child or parent has been subject to battery or extreme cruelty.
A "qualified alien" is potentially eligible for SSI if he or she meets one of the following conditions:

1. Was receiving SSA on August 22, 1996 and is lawfully residing in the US; 2. Is lawfully admitted for permanent residence and has 40 qualifying quarters of work. Work done by a spouse or parent may be counted toward the 40 quarters of work. Some restrictions may apply if the non-citizen or the working spouse or parent received certain Federally funded benefits after December 31, 1996;
Important: If you entered the U.S. on or after 8/22/96, then you may not be eligible for SSI for the first five years as an LAPR even if you have 40 qualifying quarters of earnings.
3. Is an active duty member of the U.S. armed forces, one of certain honorably discharged veterans, or one of certain dependents of U.S. military personnel; 4. Was lawfully residing in the United States on August 22, 1996 and is blind or disabled; 5. Filed for SSI within 7 years of being granted status as a refugee, asylee, Cuban and Haitian entrant, Amerasian Immigrant, or deportation or removal is being withheld.

A qualified alien in one of these categories may be eligible for a maximum of 7 years from the date status was granted. If a qualified alien in one of these categories also meets one of the conditions listed above, then SSI can continue beyond the 7 - year period. In addition to qualified aliens who must meet a condition for eligibility, there are certain categories of non-citizens who are exempt for SSI. These categories include certain Canadian-born American Indians and non-citizens members of a Federally recognized American Indian tribe.

A non-citizen may also be eligible under certain circumstances if the Department of Health and Human Services determines that he or she meets the requirements of the Trafficking Victims Protection Act of 2000.

## SOC. SEC. DISABILITY APPLICATIONS AND ENTITLEMENTS

### 13. How do I apply for SSD or SSI benefits?

You can telephone the SSA at 1-800-772-1213 and select the option of either having your application taken over the telephone or by going to your local social security office to apply for benefits. The 800 number is open between 7:00 a.m. to 7:00 p.m. The teleservice is most busy on Mondays and Tuesdays and between 10:00 a.m. and 3:00 p.m. daily.

### 14. If I want to apply for SSDI benefits, what are my next steps?

To expedite your SSDI claim, gather the following information:
1. Your Social Security number.
2. Contact information for doctors and hospitals that have treated you, including dates.
3. Your most recent W2.
4. Call 1-800-772-1213 or contact your local Social Security office to apply for benefits.

5. You may apply for dependent SSDI benefits at the same time.

## 15. How do I contact Social Security?

For more information, visit the SSA website at www.socialsecurity.gov or call toll free, 1-800-772-1213 (for the deaf or hard of hearing, call the TTY number, 1-800-325-0778).The SSA can answer specific questions from 7a.m. to 7p.m. Monday through Friday and can provide information by automated phone service 24 hours a day.

The SSA will treat all calls confidentially, and also wants to make sure you receive accurate and courteous service. That is why the SSA will have a second Social Security representative monitor some telephone calls, so be sure to be courteous and kind as well.

So we hope that this information has been helpful. If you are disabled and approaching retirement age, or if you need any further information concerning the inter-play of disability, (SSDI) retirement and which would benefit you and your family, you may contact Mike Murburg through our website www.disabilityattorney.net.

## 16. Do I need medical evidence to win my SSDI or SSI case?

Yes. Your disability claim whether it is SSI or SSDI must be supported by objective material medical evidence of record, meaning diagnoses during doctors visits and by medical test results like MRI, CT Scans, X-Rays and blood tests. It is established law that the lack of medical treatment is a strong factor against finding disability. Moreover SSR 02-1p restricts the award of benefits to those claimants who do not refuse to follow prescribed treatment, like giving up smoking in COPD cases, or by failing to take precsribed medications, or by failing to stop using illegal drugs or alcohol, when those substances can exacerbate physical and mental illnesses. The simple rule is that you must treat medically and follow what your doctor prescribes or you may expect no help from the SSA. There can be extenuating circumstances though which will be covered further in this tome.

## 17. Do I need appropriate medical care while my application is pending?

No one needs good medical care more than the disabled. Moreover, medical treatment records from your treating physicians provide the most important evidence of disability in a social security case. Obtaining medical reports and sending your doctor the proper forms and questionnaires concerning your care may be something best left for an experienced lawyer to do.

**18. If I don't have any regular health care, how do I get medical treatment while I am waiting for a decision from the Social Security Administration?**

Sorry, you may be on your own, look to a charity or indigent government programs.

**19. How many times do I have to get turned down by Social Security before I get my benefits?**

Many people get turned down the first time they apply. Rather than going back and filing a new SSDI or SSI claim, one whom is denied can and should appeal his or her case. By failing to appeal your case, you will lose the benefits to which you would otherwise be entitled and start a new application based on a later date. This means less money for you and your family. Moreover, if you have worked enough quarters to be insured under SSDI, you only remained insured for five years or less after you stopped working. By waiting and refilling after being turned down, one could be outside of his or her period of insurance and not be able to receive SSDI benefits. So, once turned down the first time, either you or your attorney will have to file a "Request for Reconsideration" within 60 days of your receipt of your initial "Notice of Disapproved Claim", Form SSA-561-U2, that you have been turned down to preserve your appeal. You will also have to file concurrently with it Form SSA-3441- BK, known as a "Disability Report-Appeal" form. If you are turned down you will receive a "Notice of Disapproved Claim" letter telling you that you must file a "Request for Hearing by Administrative Law Judge." After that, you or your attorney will again have to file within 60 days another form, a "Request for Hearing by Administrative Law Judge", Form HA-601-U5, and again a "Disability Report-Appeal" form.

**20. Does persistence help?**

Yes. Be persistent. Social Security disability benefits can help you and your family significantly.

**21. Do you have any special tips in dealing with the SSA?**

Yes. Once you call SSA and actually talk to a claims representative, always ask for his or her telephone number. They are unlisted, and you cannot get them from the phone company. Do not lose the number, save the number so you can re-contact your claim representative in 3 or 4 days for a follow-up.
The SSA is a gigantic bureaucracy. Make sure to write down the names, dates and location of everyone you talk to at SSA, and, if you complete forms always keep copies, and, if at an SSA office, ask to be provided with stamped and dated copies of the records

you submit. Organize your records in a file and always bring your own records to the SSA office and ask for a supervisor if you have a problem.
Finally, dealing with the SSA can be frustrating and disheartening. Do not let yourself despair. Seek help if you need it and never give up.

**22. If I am a Social Security Disability Claimant and a Veteran who has applied for Social Security Disability or SSI Benefits, must my VA Doctor assist me in completing paperwork helpful to my Social Security Disability or SSI case?**

Yes. According to VA Directive, a claimant's VA Physician is mandated by VA Directive 2008-071 to render assistance to the claimant in completing forms that will assist the claimant in his petition for Social Security Benefits and benefits through other Federal programs.

A copy of VA Directive 2008-071 may be found in the Appendix of this Publication.

**23. What is my "Alleged Date of Onset of Disability," and why is it important to select the correct date?**

The date alleged for an onset of disability "AOD" is the date from which entitlement to Social Security Disability Insurance benefit entitlement (less the 5 month elimination period for financial entitlement and payments), SSI (immediate entitlement to payment of funds on AOD), Medicaid (immediate entitlement on AOD) and Medicare (less the 2 year elimination period) entitlements run. The AOD should be the first day when a claimant was unable to engage in SGA, "Substantial Gainful Activity". This term of art when broken down essentially means, "Could a claimant work a 40 hour week without significant interruption from symptoms and/or need for treatment?" AND, no matter how sick the claimant was, and no matter how many workdays the claimant missed, was the claimant still able to make gross earnings of $940 per month? If the answers to both are "No", then the claimant is unable to engage in SGA and hence, is disabled by the required definition AOD and SGA have different applications and erroneous interpretations by those unfamiliar with the application of the term. For example, in cancer cases, the patient is most often denied because the SSA will take a wait and see attitude. This is because people do get better, and the applicant must be incapable of SGA for at least 12 months after their AOD.

Regarding the proper onset date of disability within the AOD, it is important to get the right onset date, as the wrong date holds up the SSD/SSI process until the proper date is decided by a judge. I have had cases, where, for example a bipolar adult will say the onset of disability began in 1977 when he was 8, but he worked until 2002 when he had a nervous breakdown from which he never recovered or returned to work. Such a case was won by seeing the error and filing a written formal motion to move the onset date to the last day of continuous work, i.e. first day of psychiatric hospitalization. Unfortunately,

we do not get these types of files until they are ready for hearing and people have suffered too long.

So, getting the proper AOD is very important. It is why an attorney should be consulted immediately after a claim is denied, so that one does not necessarily have to wait for a hearing.

**24. What date should I use for my "Alleged Onset Dater of Disability" when I apply for Social Security Disability?**

Many people who are seeking disability may have a long-standing condition, like diabetes or depression. Often they make the mistake of using the first date on which they received a diagnosis of their illness. This complicates matters in their cases, especially when a claimant has worked after the date. Citing too early a date is a common cause of gumming up the system and preventing a claimant from getting his or her benefits. Use too early a date, and you will wait years for your hearing. Use too late a date, you may be past your last date for SSDI insurance and get nothing. As a rule of thumb, your alleged date of onset should be the day after the last date on which you were able to work at any job at a full time bases. This is often the date when a claimant finds himself or herself unable to work at all or only work a few hours per day or a couple of days per week because of a disabling condition. REMEMBER, ONE CAN HAVE A "DISABILITY" AND STILL NOT BE "DISABLED".

**25. What do Social Security Disability and Social Security Retirement have to do with each other?**

If you were born before 1938, your full retirement age is 65. Because of the 1983 change in law, the full retirement age will increase gradually to 67 for people born in 1960 or later. Some people retire before their full retirement age. You can retire as early as early as 62 and take benefits at a reduced rate. If you work after your retirement age, you can receive higher benefits because of additional earnings and credit for delayed retirement. If you are disabled prior to your full retirement age, your retirement will not be reduced.

Disability- for example, if you become disabled before full retirement age, you can receive disability benefits after six months if you have:

** enough credits from earnings (depending on your age, you must have earned six to 20 of your credits in the three to 10 years before you became disabled); and

** a physical or mental impairment that's expected to prevent you from doing "substantial" work for a year or more or result in death.

If you are filing for disability benefits, please let the Social Security Administration know if you are on active military duty or are a recently discharged veteran, so that the Social Security Administration can handle your claim more quickly. There is an offset for Non-Service Connected VA disability benefits against your SSDI but not for VA service connected Disability Benefits thus allowing entitled Veterans to collect both Social Security Disability and Service Connected VA Disability Benefits.
Family- If you are eligible for disability or retirement benefits, your current or divorced spouse, minor children, or adult children disabled before age 22 also may receive benefits. Each may qualify for up to 50 percent of you benefit amount.

Survivors- When you die, certain members of your family may be eligible for benefits:

** your spouse age 60 or older (50 or older if disabled, or any age if caring for your children younger than age 16); and

**your children if unmarried and younger than age 18, still in school and younger than19 years old, or adult children disabled before age 22. If you are divorced, your ex-spouse could be eligible for a widow's or widow's or widower's benefit on you record when you die.

Extra Help with Medicare- If you know someone who is on Medicare and has limited income and resources, extra help is available for prescription drug costs. The extra help can help pay the monthly premiums, annual deductibles, and prescription co-payments. To learn more or to apply, visit www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

**26. If I am getting close to early retirement age, even if I think I am disabled, why shouldn't I just forget about filing for SSDI and file for early SSA Retirement?**

Carefully consider the advantages and disadvantages of early retirement. If you choose to receive benefits before you reach full retirement age, your monthly benefits will be permanently reduced, unless you are adjudicated as disabled. To help you decide the best time to retire, the Social Security Administration offers a free booklet, Social Security-Retirement Benefits (Publication No. 05-10035) that provides specific information about retirement. You can calculate future retirement benefits on the Social Security Administration website at www.socialsecurity.gov by using the Social Security Benefits Calculators.

Other helpful free publications include:
* Understanding The Benefits (No. 05-10024)
*Your Retirement Benefit: How it Is Figured (No. 05-10070)
*Windfall elimination Provision (No. 05-10045)
*Government Pension Offset (No. 05-10007)
*Identity Theft And Your Social Security Number (No. 05-10064)

The Social Security Administration also has other leaflets and fact sheets with information about specific topics such as military service, self-employment or foreign employment. You can request Social Security publications at the Social Security Administration website, www.socialsecurity.gov, or by calling the Social Security Administration at 1-800-772-1213. The Social Security Administration website has a list of frequently asked questions that may answer questions you have. The Social Security Administration easy-to-use online applications for benefits that can save you a telephone call or a trip to a field office can be found on line. You may also qualify for government benefits outside of Social Security. For more information on these benefits, visit www.govbenefits.gov.

**27. If I am disabled or thinking of retiring what are my options and what do I need to consider?**

As you approach the age when you can receive Social Security retirement benefits, you have options to consider and decisions to make. Before making your retirement decisions, a filing for disability, we hope you will consider all the options.

There are important questions that you need to ask yourself. At what age do you want to begin receiving benefits? Do you want to stop working and receive benefits? Do you want to work and receive benefits at the same time? Or do you want to work beyond your full retirement age and delay receiving benefits? Will it be financially advantageous to go on disability and file for retirement?

When you continue working beyond full retirement age, your benefits may increase because of your additional earnings. If you delay receiving benefits, your benefits will increase because of the special credits you will receive for delaying your retirement. This increase benefit could be important to you later in life. It also could increase the future benefit amounts your family and survivors could receive. This is why you should also consider filing for SSDI if you are incapable of working the equivalent of a 40 hour work week due to physical or mental limitations.

Each person's retirement situation is different. It depends on the circumstances such as health, financial needs and obligations, family responsibilities, amount of income from work and other sources. It also may depend on the amount of your Social Security benefit.

We hope the following information will help you make your retirement decision.

If I decide to file for SSDI, will Social Security disability insurance help my dependents?

Yes. If you are approved for SSDI benefits, other family members may also qualify for benefits.
Generally, benefits will be available for:

children under 19 who have not finished high school
a spouse who is caring for a child under the age of 16
a spouse over age 62

To avoid unnecessary delays, apply for SSDI dependent benefits at the same time you are applying for your own benefits.

**28. So, why shouldn't I just file for my Social Security Retirement Benefits early and not file for Social Security Disability?**

There are advantages of receiving Social Security disability benefits. When people think of Social Security, they think of retirement benefits. But Social Security also provides financial protection in the event that you suffer a serious disability, regardless of your age. This protection is provided under the Social Security Disability Insurance program (SSDI). Think of Social Security as an insurance program that you paid for through Social Security (FICA) taxes that were deducted from your paycheck.
There are a number of advantages to receiving Social Security disability benefits. Depending on your individual circumstances, advantages may include:
Higher Social Security retirement benefits: Generally, Social Security retirement benefits are calculated based on your average earnings during your working life. For people whose earnings have been reduced due to disability, this can mean lower retirement benefits. However, if you are approved for Social Security disability benefits, your Social Security retirement benefits will be calculated based on your earnings before your became disabled.
The impact of SSDI on your Social Security retirement benefit is significant. For example, an individual earning $50,000.00 a year who became disabled at age 40 and remained disabled until retirement would receive more than $130,000.00 in additional retirement benefits over a 20-year retirement:
We therefore recommend that you protect your future retirement benefits by filing for Social Security Disability.
Medicare eligibility: If you are found to be disabled, you will become eligible for Medicare 24 months after your Social Security effective date, regardless of your age. This is important, especially if you do not have or cannot afford private health insurance.
Automatic cost of living increases: Every year, Social Security gives SSDI recipients an increase in their benefits based on the Consumer Price Index.

**29. I hate not working and being without any money for medicine or food. Should I try to work after I have filed for SSDI or SSI?**

You can try. I always tell my clients "Don't live your life for a lawsuit or a disability claim, we deal with facts and proof, you have to deal with life". If your return to work is less than six months generally and you earn less than approximately $900.00 per month,

it should not be counted against you if you are forced to discontinue your work due to your disabling condition. It is known as an "unsuccessful return to substantial gainful activity or employment". There are other determinations of employment known as "Extended Periods of Employment and "Trial Work Periods" which may apply if you are found to be disabled.

**30. What happens if I try to return to work?**

We always recommend that our clients not live their lives for a lawsuit or a Social Security Disability claim. If you can return to work and do and subsequently fail, the Social Security Administration may deem that an unsuccessful return to work, if the monies you earn are not significant or your return to work lasts generally less than six months. If you return to work and succeed, you may have your claim changed from an open-ended period of disability to a closed ended period of disability, as long as your disability made you unable to work for twelve months or more. If your return to work is successful, please let us know in writing and as to whether you want to continue on with either an open ended or closed ended period of disability.

**31. What if I have investment income, (stocks, bonds, rental income)?**

That does not generally constitute substantial gainful activity, unless you are substantially active in producing that income. This gets a bit difficult with dividends from a small business or corporation and with rental income, as these often involve some gainful activity to produce the income other than just receiving and depositing a check or moving monies from place to place on your computer. Of course, work and investment income will affect directly your SSI (Supplemental Security Income) claim as there is a need based financial offset involved.

**32. If I am struggling with a physical or mental diagnosis and problem and I am still working part-time, should I file for Social Security Disability or SSI?**

If you are still working and earning gross wages of $940.00 per month or have not worked "on the books" for 5 of the last 10 years and gained sufficient "quarters" i.e. 20, you do not financially qualify for SSD or SSI no matter how sick you are, As of 2008, if you earn more than $740/mo or have property in excess of $2,000.00 you are not entitled to SSI. When you cannot make this amount due to your physical or mental conditions then file for Social Security Disability and contact us to set and appointment and look at your case.

**33. What if I cannot keep my job due to being late or absent on account of my illness?**

Keep track of your pay stubs and keep a calendar upon which you should mark the days you were sick or late or had to go home early from work on account of your illness. Keep track of doctor's visits too. If you have co-workers who know of your condition, keep in touch with them as, when it is time for you to stop work, you may ask them to write a statement for you about how you were unable to perform your job full time or without required help. Remember that if you get laid off due to economic circumstances, it will be presumed that you could have remained working and employed and not disabled and that your lack of work was based on economic circumstances, not your disability. This presumption can be overcome with testimony and medical records however.

**34. If I have earnings after I apply for SSDI or SSI, should I report them?**

Yes. Another reason people are denied benefits and have to wait for a hearing is because earnings show up on their record. This will almost always guarantee a long wait for a hearing. So, report all income to SSA and explain it. Do this even if it is Workers' Compensation Benefits, Unemployment benefits, Long term and Short-term disability benefits. Do not only report the amount, but the source of the benefits and the nature of them, what they were for. This will have to be clarified at some point and if you do it during the pre-hearing process, you may avoid a long, unnecessary wait for a Social Security Disability Hearing.

**34.a. Can I collect Unemployment Benefits and still apply for and get Social Security Disability?**

That is a tricky question. Many judges look at this issue unfavorably. Technically, when you ask for unemployment, you are saying that you can work, and if you ask for SSD or SSI, you are saying that you cannot work. These are two opposite positions to some Judges. In fact, they are not opposite positions. The difference is very important. When one applies for unemployment benefits, one is saying that he or she is ready, willing and able to work at any job, even part time that he or she can do physically or mentally. With SSDI or SSI, one is stating, to the Social Security Administration that they cannot return to their former employment or do other substantial gainful employment for which they are mentally and physically able eight hours per day, forty days per week because their impairments prohibit such full time work or the regular and ongoing ability to earn more than $940.00 per month.

**35. What are Disabled Widow's, Widower's or Surviving Divorced Spouse's Benefits, and how is entitlement to these benefits determined?**

To get these benefits, you must have been married to your deceased spouse for at least 10 years, be a widow or widower or surviving spouse and be at least 50 years of age. Your health problems must:

* Keep you from doing any kind of substantial work (described below), and
* last, or be expected to last for at least 12 months in a row, or result in death, and
* have started before the end of a special period.

The special period starts with the latest of:
* The month your spouse died, or
* The month your Social Security benefits as a parent ended, or
* The month your earlier period of widow(er)'s disability ended.

The special period ends at the close of the 84th month (7 Years) after the month it started.

**36. Maybe I can work part time. If I do or try to, can I receive widow, widowers, or surviving spouse benefits and still work?**

You can work and still get retirement or survivors' benefits. If you are younger than your full retirement age, there are limits on how much you can earn without affecting your benefit amount. When you apply for benefits, the Social Security Administration will tell you what the limits are and whether work would affect your monthly benefits. When you reach full retirement are, the earning limits no longer apply.

**37. Will I lose my Social Security disability benefits if I return to work?**

Not necessarily. You can continue to receive Social Security benefits for at least nine months after you return to work. If you can't continue to work beyond this nine-month period, your Social Security benefits will continue.

In addition, your Medicare will continue for at least 8 ½ years after you return to work. These work incentives allow you to test your ability to work without fear of losing your benefits.

For more information regarding work incentives, see the "Red Book on Work Incentives" published by the SSA - www.ssa.gov/work/ResoucesToolkit/redbook_page.html.* See: *How Work Affects Your Benefits (publication No. 05-10069)

**38. If I am receiving VA Disability, should I let Social Security know and give them a copy of my VA Award notice before my case is set or soon after my case is set for hearing?**

Yes. The ALJ will consider a favorable decision by the VA to award you benefits as favorable evidence in your case so make sure you provide SSA with written notification

**38.a. What are "Wounded Warrior's Benefits" and how may I be entitled to them?**

The "Wounded Warrior Program" allows service personnel who were on active military service on or after October 1, 2001 to receive expedited processing of their Social Security Disability Claims. There is also a related program through the Department of Defense. Both require a separate application. The SSA program allows for a wounded warrior to file for benefits, even while collecting military pay when the claimant is unable to do substantial work because of his/her medical condition which has lasted or is expected to last for 12 months or more.

In "Wounded Warrior" cases the amount of pay a wounded warrior receives is not the controlling factor in determining disability. The actual work activity is. A wounded warrior might work in sheltered employment for the Army during his/her periods of in-patient and out-patient medical treatment. Had the soldier had "employment" where he could sit, stand and walk at his option and had a desk from which to work and if the wounded warrior could come and go as he pleased and was taken to his medical appointments by the car pool established at his unit where he reported for duty while on the program AND was allowed to rest and not have to engage in any activities related to his work and to lie down at the facility for two or more hours per day, this would probably not be considered "substantial work for pay or profit." This is because these allowances are part and parcel of sheltered work and not a competitive job environment.

Such sheltered "employment" though creates a very gray area for these veterans both as a matter of entitlement, due to their earnings and activities in the workplace and what might otherwise be termed Substantial Gainful Activity, or SGA, and the potential for benefits that might otherwise awarded. Unfortunately Congress did not give much guidance in this area and the subject is presently about as clear as mud. One can imply though, a wide latitude given to both the Department of Defense and to the Social Security Administration in making sure these wounded warriors are not without funds with which to keep them and their families. That is the only clear intent I can glean from the law in this area. Remember that service connected disability benefits and SSDI benefits are available simultaneously to veterans and such "double dipping" is not only allowed but encouraged with present laws.

The bottom line is to file as early as you can for WW benefits. Document your job duties while you are still working and how much or how little was required of you. Keep in touch with your work supervisors who can testify on your behalf as to your ability to work less than a full week and get your treating physicians to set plausible work restrictions on you as early as possible.

## THE SOC. SEC. DISABILITY APPEALS PROCESS

**39. If I get turned down, how do I appeal my initial Unfavorable Supplemental Security Income (SSI) or Special Veterans Benefit (SVB) decision?**

There are three different ways to appeal: Case Review, Informal Conference, and Formal Conference. You can pick the appeal that fits your case. You can have a lawyer, friend, or someone else help you with your appeal.

1. Case Review:

This is the most cursory form of review. You can give the VA more facts to add to your file. Then the SSA will decide your case again. You don't meet with the person who decides your case. You can pick this kind of appeal in all cases.

2. Informal Conference:

This form of appeal is "less appealing" to most practitioners. Here, you'll meet with the person who will decide your case. You can tell that person why you think you're right. You can give the SSA more facts to help prove you're right. You can bring other people to help explain your case. You can pick this kind of appeal in all SSI cases except two. You can't have it if the SSA turned down your SSI application for medical reasons or because you're not blind. Also you can't have it if the SSA is giving you SSI but you disagree with the date they said you became blind or disabled. In SVB cases, you can pick this kind of appeal only if the SSA is stopping or lowering your SVB payment.

3. Formal Conference:

Most attorneys and representatives prefer this sort of meeting as it affords the claimant the greater amount of due process rights. This is a meeting like an informal conference. Plus, the SSA can make people come to help prove you're right. The SSA can do this even if they don't want to help you. You can question these people at your meeting. You can pick this kind of appeal only if the SSA is stopping or lowering your SSI or SVB payment. You can't get it in any other case.

Now that you know the three kinds of appeals. You can pick the one that fits your case. Then fill out your "Request for Reconsideration" form. The SSA will help you fill it out if you ask.

There are groups that can help you with your appeal. The SSA can give you the names of these groups or attorneys to help with your appeal. We represent Veterans at the Law offices of Mike Murburg, P.A. and at Disabilityattorney.net. One of our representatives, Carol Wilson, tried her first VA case over twenty years ago.

**40. What administrative actions are initial determinations from which I can file a "Request for Reconsideration" or an appeal?**

The following list covers the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

For Title II Claims (Social Security Disability Insurance) SSDI, the following are considered initial determinations from which one can appeal:

1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefits;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf, to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if the SSA determines that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of a claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

For Title XVI Claims (Supplemental Security Income) SSI the following are considered initial determinations from which one may appeal:

1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;

4. Whether payments will be made on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if the SSA determines that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion of or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continue even though he or she is not disabled.

Note: Every re-determination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)

1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension, or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II—items 3, 4, 10, 11, & 16.

Title XVIII (SSI)

1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.

**41. Where can I find these Appeal Forms?**

You may request a "Request for Reconsideration", SSA-561-U2 form on line at http://www.socialsecurity.gov/online/ssa-561.pdf. You may find and complete your "Disability Report-Appeal" on line at http://www.socialsecurity.gov/online/ssa-561.pdf. You can call the SSA at 1-800-772-1213 or go on line to file your "Request for Hearing by Administrative Law Judge", Form HA-601-U5, at the Social Security Website at

http://www.socialsedcurity.gov/disability/hearing. You can also find these forms in the Appendix or on our website www.disabilityattorney.net and click the appropriate links.

The same is true with the following appeals forms:
"Request for Reconsideration", Form SSA-561-U2.
"Disability Report-Appeal", Form SSA3441-BK.
"Request for Hearing by Administrative Law Judge", Form HA-501-U5.

**42. What if SSA discourages me from applying or appealing?**

Of the people who apply for SSD, over 50% are turned down (from SSA stats). Fewer than 50% of those are turned down appeal. Of those who appeal, over generally 50% are accepted disabled. You should not be discouraged by a SSA representative from filing. You should not necessarily believe them when they tell you that you are not disabled.

**43. What do I do if I get turned down?**

If you really cannot work in a full time or regular scheduled part time capacity due to injury or illness that has prevented you from working or will keep you from working for 12 months or more, apply for Social Security Disability (SSD) and Supplemental Security Income benefits. If you are tuned down you will have 60 days to file your appeal. Keep appealing denials at least through the hearing before an Administrative Law Judge. If you fail to file your appeal, you may lose valuable rights to you entitlement to SSD/SSDI benefits. Remember, the law does not help those who sit on their rights. According to the Social Security Administration, the biggest mistake people make when trying to get disability benefits is failing to appeal or waiting too long (more than 60 days) to file their ""Request for Reconsideration" and/or "Request for Hearing".

**44. What form do I have to file in order to get my hearing?**

The form one must file to get a hearing is a Form HA-501-U5 form called a "Request for Hearing by an Administrative Law Judge". The Form is set forth in the Appendix hereto.

**Is there another form that must accompany my "Request for Reconsideration" and "Request for Hearing"?**

Yes. You must also file a Form SSA-3441-BK "Disability Report-Appeal" also set forth in the Appendix hereto.

**45. How should I send these forms?**

You should send them together within the 60 days you have to send the forms and get them to the SSA. Sending the forms certified mail, return receipt requested, is the best way to do this. Also keep a copy of the documents you send for your own records. If one hand delivers the forms, he or she should ask the SSA for a date stamped copy to confirm that the forms and your appeal has been timely filed. One can also file the appeal via the internet.

### 46. How can I locate my local Social Security Office?

You can go to the following website and type in your address and you can find the nearest Social Security Disability Office by going to: http://www.socialsecurity.gov/ and clicking on the informational tab named "find your local office." Just enter your zip code and the office closest to you will appear.

### 47. What if I let the 60 days run on my appeal, can I file late?

Yes. According to the Social Security Administration you can file your appeal (your Request for Reconsideration and/or Request for Hearing by an Administrative Law Judge) after 60 days if you have good cause for late filing.
In determining whether the claimant had good cause for failure to file a timely appeal request SSA considers:

A. whether circumstances impeded the claimant's efforts to pursue his/her claim;
B. whether SSA/CMS actions were confusing or misleading;
C. whether the claimant understood the requirements of the Social Security Act (the Act), resulting from amendments to the Act, other legislation, or court decisions; and
D. whether the claimant's physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) prevented him/her from filing a timely request or from understanding or knowing about the need to file a timely request for appeal.
NOTE: Good cause for late filing may apply to any person standing in the place of the claimant, like the claimant's representative or attorney.

Circumstances where good cause may exist include, but are not limited to, the following situations:

A. the claimant was seriously ill and was prevented from contacting SSA in person, in writing, or through a friend, relative, or other person;
B. there was a death or serious illness in the claimant's immediate family;
C. pertinent records were destroyed or damaged by fire or other accidental cause;
D. the claimant was actively seeking evidence to support his/her claim, and his/her search, though diligent, was not completed before the time period expired;

E. the claimant requested additional information concerning SSA's determination within the time limit. (After receiving the information, the individual has 60 days to request a reconsideration or hearing. The individual has 30 days after receipt of such information to request AC review or file a civil action);
F. the claimant was furnished confusing, incorrect, or incomplete information or was otherwise misled by a representative of SSA or CMS about his/her right to request continued benefits, reconsideration, a hearing before an Administrative Law Judge, AC review, or to begin a civil action;
G. the claimant did not understand the requirement to file timely or was not able (mentally or physically) to file timely;
H. a notice of the determination or decision was never received (e.g., SSA used incorrect address or claimant moved);
I. the claimant transmitted the appeal request to another government agency in good faith within the time limit and the request did not reach SSA until after the time period had expired;
J. the claimant thought his/her representative had filed the appeal (good cause applies to the claimant despite whether the claimant is still represented or represented by a different person);
K. unusual or unavoidable circumstances exist, which demonstrate that the claimant could not reasonably be expected to have been aware of the need to file timely, or such circumstances prevented him/her from filing timely.

### 48. Once my Request for Hearing is received by the SSA what happens next?

Your Request for Hearing will be received by the Social Security Office and will be forwarded along with your disability file to "ODAR" (the Office of Disability Adjudication and Review) formerly known as the Office of Hearings and Appeals.

### 49. How Can One Expedite a Hearing on a Social Security Disability/SSA Claim?

A "Dire Need" situation exists when a person has insufficient income or resources to meet an immediate threat to health or safety, such as lack of food, clothing, shelter or medical care. The claim must allege specific immediate circumstances.

Expeditious hearing requests are routinely denied unless a claimant meets at least one of four circumstances:

The first is whether the claimant is 55 years of age or older. This is because at 55, claimants fall into a less restrictive disability category. As a consequence, the claim is more easily decided by a Social Security Administration judge. We automatically file expeditious requests once all of our clients reach the age of 55.

The second category for expeditious handling is when the claimant is at a critical risk for death if emergency life saving surgery is not performed immediately. This must be put in writing by the claimant's physician and given to us so that we can request an expeditious hearing on the claim. Terminal illness or (TERI) cases or "Compassionate Allowance" cases must clearly set forth the emergency medical situation involved.

The third area ripe for expeditious handling is when a claimant is in receipt of a Notice of Eviction, foreclosure or acceleration of mortgage payments. This takes an official legally driven notice, not just some handwritten piece of paper from your relative/landlord that you cannot stay there anymore.

The fourth area is a Military Service Casualty Case (active military service, occurring after October 1, 2001 in US or abroad).

The fifth is when there is an indication that the claimant is suicidal or homicidal.

Unfortunately, with the extreme backlog of cases pending with the Social Security Administration, these bases are just of historical note and are now seldom if ever granted. We do file them with the Social Security Administration and make the request if and when our clients send such notice to us.

Unfortunately, there are no further bases under which to ask for an expedited hearing. We do not recommend that our clients contact their U.S. Senator or Congressman with their request unless they are a disabled American Veteran who has already received a VA in-the-line-of-duty disability award.

Remember that a request for an expedited hearing may only move your hearing up a few months. It is only in extremely rare cases that the request to expedite is granted and the hearing takes place within 90 days.

**50. Is there a list of conditions for TERI Cases that can trigger my case as one of Dire Need?**

Yes. These cases are called "Compassionate Allowance" cases.

The following are Compassionate Allowances that will expedite your hearing or case.
List of Conditions

1. Acute Leukemia
2. Adrenal Cancer - with distant metastases or inoperable, unresectable or recurrent
3. Alexander Disease (ALX) - Neonatal and Infantile
4. Alstrom Syndrome.
5. Amegakaryocytic Thrombocytopenia
6. Amyotrophic Lateral Sclerosis (ALS)

7. Anaplastic Adrenal Cancer - with distant metastases or inoperable, unresectable or recurrent
8. Aortic Atresia
9. Astrocytoma - Grade III and IV
10. Ataxia Telangiectasia
12. Batten Disease
13. Bilateral Retinoblastoma
14. Bladder Cancer - with distant metastases or inoperable or unresectable
15. Bone Cancer - with distant metastases or inoperable or unresectable
16. Breast Cancer - with distant metastases or inoperable or unresectable
17. Canavan Disease (CD)
18. Cerebro Oculo Facio Skeletal (COFS) Syndrome
19. Chronic Myelogenous Leukemia (CML) - Blast Phase
20. Creutzfeldt-Jakob Disease (CJD) – Adult
21. Cri du Chat Syndrome
22. Degos Disease, Systemic
23. Early-Onset Alzheimer's Disease
24. Edwards Syndrome (Trisomy 18)
25. Eisenmenger Syndrome
26. Endomyocardial Fibrosis
27. Ependymoblastoma (Child Brain Tumor)
28. Esophageal Cancer
29. Farber's Disease (FD) – Infantile
30. Fibrodysplasia Ossificans Progressive
31. Friedreichs Ataxia (FRDA)
32. Frontotemporal Dementia (FTD), Picks Disease -Type A - Adult
33. Gallbladder Cancer
34. Gaucher Disease (GD) - Type 2
35. Glioblastoma Multiforme (Adult Brain Tumor)
36. Glutaric Acidemia Type II (Neonatal)
37. Head and Neck Cancers - with distant metastasis or inoperable or uresectable
38. Heart Transplant Graft Failure
39. Heart Transplant Wait List, 1A/1B
40. Hemophlangic Lymphohistiocytosis (HLH), Familial Type
41. Hypolastic Left Heart Syndrome
42. Idiopathic Pulmonary Fibrosis
43. Infantile Neuroaxonal Dystrophy (INAD)
44. Infantile Neuronal Ceroid Lipofuscinoses
45. Inflammatory Breast Cancer (IBC)
46. Junctional Epidermolysis Bullose, Lethal Type
47. Kidney Cancer - inoperable or unresectable
48. Krabbe Disease (KD) - Infantile
49. Large Intestine Cancer - with distant metastasis or inoperable, unresectable or recurrent
50. Late Infantile Neuronal Ceroid Lipofuscinosis

51. Left Ventricular Assist Device (LAD) Recipient
52. Leigh's Disease
53. Lesch-Nyhan Syndrome (LNS)
54. Liver Cancer
55. Mantle Cell Lymphoma (MCL)
56. Maple Syrup Urine Disease
57. Merosin deficient Congenital Muscular Dystrophy
58. Metachromatic Leukodystrophy (MLD) - Late Infantile
59. Mitral Valve Artesias
60. Mixed Dimentias
61. MPS I, formerly known as Hurler Syndrome
62. MPS II, formerly known as Hunter Syndrome
63. MPS III, formerly known as sanfilippo Syndrome
64. Mucosal Malignant Melanoma
65. Neuronal Adrenouleukodystrophy
66. Niemann-Pick Disease (NPD) - Type A
67. Niemann-Pick Disease (NPD) - Type C
68. Non-Small Cell Lung Cancer - with metastases to or beyond the hilar nodes or inoperable, unresectable or recurrent
69. Ornithine Transcarbamylase (OTC) Deficiency
70. Osteogenesis Imperfecta (OI) - Type II
71. Ovarian Cancer - with distant metastases or inoperable or unresectable
72. Pancreatic Cancer
73. Patau Syndrome (Trisomy 13)
74. Peritoneal Mesothelioma
75. Pleural Mesothelioma
76. Pompe Disease – Infantile
77. Primary Cardiac Amyloidosis
78. Primary Progressive Aphasia
79. Primary Multifocal Leukoencephalopathy
80. Pulmonary Artesia
81. Rett (RTT) Syndrome
82. Salivary Tumors
83. Sandhoff Disease
84. Single ventricle
85. Small Cell Cancer (of the Large Intestine, Ovary, Prostate, or Uterus)
86. Small Cell Lung Cancer
87. Small Intestine Cancer - with distant metastases or inoperable, unresectable or recurrent
88. Spinal Muscular Atrophy (SMA) - Types 0 And 1
89. Spinocerebellar Ataxia
90. Stomach Cancer - with distant metastases or inoperable, unresectable or recurrent
91. Subacute Sclerosis Panencephalitis
92. Tay Sachs Disease-Infantile Type
93. Thanatorphoric Dysplasia, Type 1

94. Thyroid Cancer
95. Tricuspid Atresia
96. Ulrich Congenital Muscular Dystrophy
97. Ureter Cancer - with distant metastases or inoperable, unresectable or recurrent
98. Walker Warburg Syndrome
99. Wolman Disease
100 Zellweiger Syndrome

You may also find these conditions listed at
http://www.ssa.gov/compassionateallowances/conditions.htm

# SOC. SEC. HEARINGS: THE ALJ LEVEL

**51. After I file my Request for an Administrative Law Judge Hearing, what will happen next?**

The Office of Disability Adjudication and Review (ODAR) will send you a letter confirming their receipt of your file.

**52. What happens at ODAR from that point on?**

ODAR will review your file to see if an immediate favorable decision is possible without holding a hearing. If not, your case will be prepared for a review by an Administrative Law Judge for hearing. Then, your case will be scheduled for hearing.

**53. How long will this take?**

Each jurisdiction is different. One can count on between 18 and 28 months generally to have a hearing. The SSA is trying very hard to shorten this wait, but as the Baby Boom generation and the Bush economy begin to have an effect on this country, the numbers will be tough to crunch without help from Congress.

**54. Will anybody tell me anything?**

You will probably receive notice of your hearing date in the mail. If you have an attorney, the SSA normally contacts your attorney to set a hearing date and to make sure that there are no problems with evidence in your case. Otherwise, you will be given Notification of the Hearing Date in the mail, approximately 20 days in advance of your hearing.

**55. Will I or my attorney be notified?**

Yes, you will. If you have an attorney, the attorney will also be notified.

**56. How will I know if my attorney has been notified?**

There will be a “cc” at the bottom of the last page with the name and address of your attorney or his or her firm at the bottom under the “cc”.

**57. What if my attorney is not copied on the Notice?**
Call your attorney immediately and send your attorney a copy of your Notice.

**58. Can I waive the 20-day Notice and get my hearing earlier?**
Yes, but this is advisable only in so far as your case filings and evidence is up to date. Judges like to make decisions based on a complete record so that your file is not languishing in their offices waiting for medical records and reports. Otherwise, you and your attorney may waive the 20-day notice in writing to get an earlier hearing slot.

**59. Is there anything else I must do to expedite my hearing request?**

Yes, To expedite your hearing request, be sure to send in all available medical and non-medical evidence inclusive of third party statements about your condition as soon as possible, as this additional evidence could make the difference in an ALJ making an earlier decision in your case.

**60. Once my case has been reviewed and accepted into the Social Security Hearing process, what happens next?**

Once your request for hearing is received by Social Security and forwarded along with your file to the Office of Disability Adjudication and Review (ODAR), ODAR will send you a letter confirming receipt of your case.

ODAR will review your case to see if an immediate favorable decision without holding a hearing is possible. If not, your case waits its turn to be prepared for hearing. The file is prepared for and reviewed by and Administrative Law Judge (ALJ) and then scheduled for hearing. Because of the large number of cases ODAR receives each month, this process can take up to 24 months or more.

You will receive notification of the hearing date in the mail approximately 20 days in advance. If you have an attorney or other person representing you, he/she will also be notified. Contact your treating Physicians to make sure you have provided your attorney with all updated medical records.

You will attend your hearing and testify. The Judge will ask you questions or ask your attorney to ask you pertinent questions. Your testimony and your work as well as your medical history will be reviewed by a Vocational Expert (VE) and/or a Medical Expert

(ME), who is a medical doctor. Your attorney (as we are at Mike Murburg P.A.) should be skilled at trial, understand vocational grids, rules and job requirements and be adept at cross-examination, so that he can cross-examine these expert witnesses and allow them to give testimony in your favor.

The ALJ will make his/her decision shortly following the hearing, providing no additional evidence has been requested.

The decision is then written, typed, corrected, and finally signed by the ALJ. It takes between six to eight weeks for the Judge to issue the decision.

In summary, you can expect to wait 24 months from the time you file your request until you actually have your hearing. You can expect to wait another 2 months until you receive your decision in the mail.

Since the decision is not final until written notice is sent, the outcome of the hearing cannot be discussed with you over the telephone prior to your receipt of a written decision.

To expedite your Hearing Request, be sure to send in all available medical and/or non-medical evidence, or have your Attorney/Representative do so as soon as possible. This additional evidence could make the difference in the Judge deciding your case sooner. So you must keep your attorney updated as to all of your physicians and listing facilities and tests as your case progresses.

At Mike Murburg P.A. we are committed to providing quality public service and doing everything possible to help your case. Submitting additional evidence will enable us to process your hearing request more quickly.

### 61. How should I prepare for a hearing?

There are many different ways to prepare but the following are the cardinal rules for getting your case prepared.

1. OBTAIN AS MUCH INFORMATION AS POSSIBLE FROM THE SSA WEBSITE. This is a general rule for all dealings with SSA. At the hearing level, the majority of claimants are represented, and the SSA encourages its employees to cooperate as much as possible with requests for information or assistance from representatives. However, every personal contact with hearing office personnel precludes the employee from performing other responsibilities relating to other hearing requests. Every five minutes that is saved on individual claims converts to thousands of saved hours that can be devoted to processing other claims.

2. TIMELY SUBMIT THE FORM SSA-1696 AND FEE AGREEMENT. If applicable, obtain and submit withdrawals and waivers from prior representatives to avoid possible delay in payment.

3. ESTABLISH A GOOD WORKING RELATIONSHIP WITH HEARING OFFICE STAFF AND MANAGEMENT. Your attorney should participate in periodic group meetings with the Hearing Office Chief Administrative Law Judge and Hearing Office Director in the offices in which you practice. Open dialogue allows both representatives and hearing offices to exchange suggestions as to how to improve service in the local area.

4. YOU OR YOUR ATTORNEY SHOULD TIMELY ALERT THE HEARING OFFICE OF ANY CHANGE OF ADDRESS OR PHONE NUMBER FOR EITHER HIMSELF OR THE CLAIMANT. This would help reduce duplication of effort by hearing offices when notices are sent to either individual.

5. YOU OR YOUR ATTORNEY SHOULD SUBMIT UPDATED SORM SSA-827 WITH THE REQUEST FOR HEARING. If the hearing office needs to request information on short notice for a possible on-the-record (OTR) decision or a dire need review, or for any other reason, it is very helpful to have updated release forms already in the file.

6. EVEN IF A CASE IS PENDING AT THE HEARING LEVEL, A FORM SSA-1695 SHOULD BE SUBMITTED TO THE SSA FIELD OFFICE, NOT THE HEARING OFFICE. This form deals solely with payment to the representative and contains personal information, including a representative's social security number. If a SSA-1695 is received at a hearing office, it is immediately forwarded to the SSA field office for processing. Submitting this form to the SSA field office initially would significantly reduce the time hearing office staff spend forwarding documentation, and reduce the likelihood that the form will either be lost or improperly associated with the claimant's file.

**62. What steps need to be taken to go before an Administrative Law Judge at the Hearing?**

Under 20 CFR §§ 404.935 and 416.1435, claimants have an existing duty to submit additional evidence with a Request for Hearing or within 10 days of submitting the request. Therefore, the SSA encourages all representatives to review the file and submit evidence as early in the hearing process as possible. Do not wait until the case is scheduled to submit evidence. ODAR is aggressively screening cases for potential "on the record" situations and updated evidence is helpful in identifying cases that may be reversed without the need for a hearing. At the same time, they also encourage representatives to be mindful of hearing office resources required to burn CDs, and ask that representatives not request excess copies of CDs.

**63. Can I use the Internet to file my medical records with the SSA or can only an attorney's office do that for me?**

At present, only an Attorney or Representative can take advantage of electronic filing. Once your file is received at your local Office of Disability Adjudication and Review (hearing office), your attorney will be able to submit medical evidence and correspondence via the electronic records express system (ERE). Social Security disability files are now being processed electronically. This system is helping to streamline and expedite the disability application process and may be available to individual litigants shortly.

**64. What is the first step in filing records electronically in the ERE System?**

In order to use the ERE system, you must first have a copy of your electronic disk from Social Security and the bar code for your file from ODAR. To order the bar code and electronic disk, one can fax his or her local ODAR a request for either, or, or both. Make sure to include the claimant's name and social security number on the request.

**65. Why do I need a copy of my SSA file on Disk?**

The Judges at the Office of Disability Adjudication and Review request that duplicate records not be submitted to the hearing office. One can use the social security disk to check what medical records the hearing office has already received in the case. It is also helpful to check the disk to make sure that the records submitted thus far have made it to the claimant's electronic file.

Warning! It will take some time for the hearing office staff to get you a copy of the electronic disk. It is also not encouraged to order these disks frequently. The hearing office staff is more than happy to help their claimants, but excessive use of this practice can lead to them rationing the amount of disks a claimant or representative can order. In our experience, the hearing office will try to limit the total number of disks they will send to either one or two disks total.

**66. Why do I need a copy of my bar code?**

Each bar code is unique to a person's file. When you send medical evidence in to the disability ERE system, the barcode directs the evidence directly to your electronic file.

**67. Once I have a bar code, how can medical evidence be electronically submitted?**

Once you have a bar code for your file, there are three ways to submit medical evidence (or any other type of correspondence) to your Social Security file. They are as follows.

1. Electronic Fax: The first process by which you can submit evidence electronically to your file is by electronic fax. All you need in order to send records this way is a facsimile cover sheet that includes your name, Social Security number, description of the attached documents, number of pages being submitted, and the time range for the records you are sending. You then place the bar code on the very top of the documents you are sending, and then fax the submission to the electronic fax number of your local hearing office (ODAR). Make sure to keep the fax confirmation page with your submission.

2. Electronic Records Express Website: In order to submit evidence by the ERE website, you must first have an account with the ERE system. In order to create an account, you can contact your local ODAR office and speak with the person in charge of handling their ERE technology. At the present moment, only attorney and non attorney representative businesses may create accounts with the ERE website. Once you have created an account, you must scan the records you are going to send to the ERE website onto you computer as a PDF document, and save the document (including its cover sheet) onto your computer, into the claimant's file. To sign in to your account go to: https://secure.ssa.gov/acu/iresear/login?URL=/apps9/ERE/home.do

Enter your User ID and Password. Once you sign in to your account, click on Send Response for Individual Case.

Step 1 (Destination and Request Information): In this screen you will enter the information found on your bar code into their equivalent slots. Once you have completed this page, press Continue.

Step 2 (Attach and Upload Files): In order to upload a file to the ERE website, it must have no punctuation in its title what so ever. You must have the file copied to the desktop on your computer in order for it to not have any punctuation in the file when you upload it. Remember to keep a copy of it in the respective file in your client database. Once the file is copied to your computer's desktop, on the ERE screen, press the Browse button, and select the file you want to submit from your desktop. Then you must press the Select Document Type, and a drop list will show you which options you can choose from. The option you choose will dictate what further information you need to complete on the page. For all medical evidence you must provide the website with the earliest date in the medical records and the latest date in the records you are submitting, as well as the treating source's name, and a brief description of what you are sending. If you have more than one submission, you can select the Add Another File button, and repeat the file attachment process. When you have added all of the submissions (up to 8 at a time) press the Submit button.

Step 3 (Confirmation): Once your files are received, it will show you a confirmation page. Press the Print button, and make sure you print as many copies of the confirmation page that you have submissions. Keep a copy of each confirmation page with each submission in your file. Pleas note that large files will take a little longer to send so please be patient.

3. Mail: If the electronic fax number or internet are not working you can submit your documents to a special electronic mailing address in London, Kentucky provided with your bar code. In order to do so, you first must copy the documents you would like to submit, as well as your bar code. Along with a cover page that includes your name, social security number, description of the attached documents, number of pages being submitted, and the time range for the records you are sending, and the copy of your documents, place the copy of your bar code on the very top of your submission. Mail this packet, unstapled, to the London, Kentucky address provided with you bar code. Each ODAR office will have a special mailing address in London, Kentucky. Keep the original documents and a copy of your cover sheet in your file. Send the package Certified Mail Return Receipt Requested so, if the SSA has no record of the records being sent, you do. This could become important later on in your case.

**68. What are the rules on submitting evidence?**

The following are the cardinal rules on submitting evidence in your case and for your hearing.

DO NOT SUBMIT DUPLICATE EVIDENCE. This is a problematic and time consuming issue that is dealt with at the hearing level and significantly delays preparation of cases for hearing. Hearing office staff often spend several hours on any given case sorting out duplicate evidence. The sooner a case is prepared and exhibited, the sooner the case can be scheduled.

1. SUBMIT EVIDENCE AS FAR IN ADVANCE OF THE HEARING AS POSSIBLE, USING ELECTRONIC RECORDS EXPRESS. Up to 200 pages at one time can be faxed into the electronic folder using the fax number and bar code supplied with the Acknowledgment of Hearing notice. However, we do recommend smaller submissions when possible (less than 30 pages), as smaller exhibits open more quickly. Early submission (more than 10 working days before hearing) allows hearing office personnel to exhibit the evidence and ensures that the claimant's copy of the file includes a copy of all the evidence that has been received. This also gives the ALJ time to review all the evidence and helps to ensure that all relevant evidence is provided in a timely manner to the experts scheduled to appear at hearing.

2. BEFORE FAXING EVIDENCE, CHECK TO ENSURE THE EVIDENCE YOU ARE SUBMITTING MATCHES THE CLAIMANT. This simple precaution would

significantly reduce the time hearing offices spend contacting representatives and re-associating evidence with the appropriate file.

3. MAKE SURE THE BARCODE IS THE FIRST ITEM FAXED IN ORDER TO ENSURE PROPER IDENTIFICATION OF ALL RECORDS. If you do not have a barcode for a particular case, please ask the hearing office to provide you with one. Bar codes may be photocopied and used more than once.

4. SUBMIT A COVER LETTER WITH THE EVIDENCE IDENTIFYING WHAT IS BEING SUBMITTED AND THE DATES OF THE EVIDENCE. This will assist hearing office staff in identifying duplicates and in exhibiting the records.

5. AVOID SUBMITTING VOLUMINOUS EVIDENCE AT THE LAST MINUTE. Submitting evidence last-minute does not provide sufficient time for hearing office staff to associate the evidence with the file or provide the ALJ and experts adequate time to review the evidence.

6. WHEN FAXING EVIDENCE FROM DIFFERENT SOURCES INTO THE ELECTRONIC FOLDER, SEPARATE SOURCES BY PLACING A BAR CODE AS THE FIRST DOCUMENT FOR EACH SOURCE AND SUBMIT IN CHRONOLOGICAL ORDER. This assists hearing office staff in reviewing the evidence for duplicates and exhibiting the records.

7. DO NOT SUBMIT MEDICAL EVIDENCE WITH NON-MEDICAL DOCUMENTS SUCH AS APPOINTMENT OF REPRESENTATIVE FORMS OR FEE AGGREMENTS. Medical and non-medical documents should be submitted separately. Because these documents are included in different sections of the folder, more time is required to separate documents if the medical and non-medical documents are submitted together.

**69. What if after I have done all the above; are there are issues to address and supporting evidence concerning those issues about which I should be aware?**

Yes.

1. WHEN POSSIBLE, OBTAIN A MEDICAL SOURCE STATEMENT FROM A TREATING SOURCE WHICH IDENTIFIES THE LIMITATIONS IMPOSED BY THE CLAIMANT'S IMPAIRMENTS. SUBMIT WITH SUPPORTING EVIDENCE OR DIRECT ATTENTION TO SUPPORTING EVIDENCE ALREADY IN THE FILE. Treating source statements can greatly assist an ALJ in assessing Step 3 of the sequential evaluation and the claimant's residual functional capacity.

2. DEAL WITH EMPLOYMENT (SUBSTANTIAL GAINFUL ACTIVITY, UNSUCCESSFUL WORK ATTEMPTS, SHELTERED WORK ENVIRONMENTS,

ETC.) OR EARNINGS ISSUES IN A PRE-HEARING MEMORANDUM OR AT THE HEARING. Be sure to distinguish long term disability, vacation, or bonus pay that may appear as earnings after alleged onset.

3. DEAL WITH WORKERS' COMPENSATION ISSUES IN A PRE-HEARING MEMORANDUM OR AT THE HEARING. If there has been a settlement, provide appropriate proof.

4. SUBMIT CONCISE PRE-HEARING BRIEFS WHENEVER POSSIBLE. This assists an ALJ in preparing for the hearing.

**70. What is an "On-The-Record" request?**

An "On-The-Record" request is a request made before or at the beginning of trial for which the claimant or his/her attorney sends this request to the court stating that the file is complete and the manifest weight of the evidence shows that the claimant is entitled to benefit under either a medical rule or vocational grid.

**71. How does one submit "On-The-Record" (OTR) Request?**

The following are the cardinal rules for submitting an "On-The-Record" request for benefits.

1. CLEARLY LABEL AN OTR REQUEST AS "OTR REQUEST" AND SUBMIT AS EARLY AS POSSIBLE (BUT ONLY WHEN A REQUEST IS APPROPRIATE). OTR requests are not appropriate in every case and should only be requested when a favorable outcome is supported by the evidence in the record.

2. IDENTIFY EVIDENCE THAT SUPPORTS THE OTR REQUEST. OTR requests should include a concise summary at the beginning of the brief outlining the argument. This should be followed by a more detailed explanation specifically directing the reviewer's attention to evidence supporting a favorable decision.

3. MAKE SURE EVIDENCE SUPPORTS ONSET DATE. Onset issues are the most frequent reason an OTR request cannot be granted.

4. USE FIT TEMPLATES TO SUBMIT OTR REQUESTS. A CD of these templates is available from hearing office personnel.

**72. What is an "Attorney Adjudicator" and how will such a person affect my case?**

Attorney Adjudicators review and screen cases for an OTR. Currently, attorney adjudicators have the authority to issue a fully favorable decision OTR when it is warranted. If you are contacted by a hearing office attorney regarding substantial gainful activity or onset issues in a particular case, discuss the matter with the attorney to see if the issue can be resolved without the need of a hearing.

**73. Do the rules change when working with Attorney Adjudicators who will be handling my case before this case is set for hearing?**

No. Prior to your case being assigned to a judge, judicial economy dictates that an experienced Social Security attorney working for the Social Security Administration will work on your case first to determine if you are entitled to benefits. This way, the work backlog for busy administrative law judges is reduced significantly.

WHEN CONTACTED, YOU SHOULD WORK WITH THE ATTORNEY ADJUDICATORS TO EXPEDITE DECISIONS IN APPROPRIATE CASES.

**74. Does Social Security handle cases of Dire Need, Compassionate Allowances, Terminal Illness and individuals who may be involuntarily confined differently than typical Social Security disability cases?**

Yes. Special rules requiring special handling apply when it comes to submitting information on cases involving these subjects.

**75. How can I submit Dire Need, Terminal Illness requests, or information regarding incarcerated individuals?**

The following rules apply.

1. NOTIFY THE HEARING OFFICE WHEN THE CLAIMANT HAS A TERMINAL (TERI) CONDITION, IS HOMELESS, OR IS IN DIRE NEED, AND INCLUDE APPROPRIATE DOCUMENTATION SUPPORTING THESE ALLEGATIONS. Notifying a hearing office of these circumstances can significantly expedite the processing of a case, if the allegation is supported. The criteria and reference links for critical case processing can be found in the provisions in HALLEX I-2-1-40 (Critical Cases).

2. WITH THE REQUEST AND DOCUMENTATION SUPPORTING THE ALLEGATION, SUBMIT UPDATED EVIDENCE SUPPORTING THE CLAIM FOR AN OTR REVIEW. If a dire need case can be awarded without the need of a hearing, this works to the advantage of the claimant and the hearing office.

3. IF CLAIMANT IS INCARCERATED, PROVIDE THE HEARING OFFICE WITH THE ADDRESS OF THE FACILITY AND THE RELEASE DATE. Many difficulties arise when an individual who has requested a hearing is incarcerated. For example, if an in-person hearing must be conducted, there are varying rules and procedures depending on the facility in which the claimant is incarcerated. Some claimants are transferred after a hearing has been scheduled but before the hearing has been held. For these types of reasons, it is very important that the hearing office is informed at all times of the status of an incarcerated claimant.

**76. Can I reschedule my hearing if I have to?**

Yes. You will need to have good grounds, like illness, sudden and unexpected lack of transportation, or the death of a close family member. You can also request that your hearing be rescheduled to give you enough time to hire an attorney and to have that attorney prepare your case before your hearing. Be careful though as administrative time is scarce and by rescheduling your hearing, you are taking time away from the judge in which he or she could be hearing your case or the case of another person who has been waiting a long time to have his or her case heard.

**76.a. What if I move out of state? What happens to my hearing?**

If you move out of state while your claim is pending, you should let Social Security know in writing. This can be a bit tricky though, if your case is at the ALJ level. If you move, your case will be transferred to the state or city where you have begun to reside. This means that your case very well may be moved back on the docket in your new jurisdiction, and you will have to wait even longer for your hearing. If you have an attorney, he or she will be getting notice for you, so if you move, let your attorney know where you are. If the move is temporary, there is no need to transfer your case from the jurisdiction in which it is pending. If you change your residence and decide that this new residence will be your permanent residence, then that is another matter. If you have an attorney or representative and can travel back to the jurisdiction where your case is pending, then your case will stay on track, and you will not lose any time waiting because of a transfer to another jurisdiction. If you transfer your case, there may be another result depending on the average hearing time prevailing in each of the relevant ODAR offices.

**77. How does a claimant go about rescheduling hearings?**

You will need to call the Office of Disability Adjudication and Review where your case is pending and speak to the scheduling clerk or secretary to get your date changed. Do not postpone your hearing unless it is essential. Be flexible with providing dates and times for hearings, and request postponements in writing in a timely fashion wherever possible. When you have already agreed to the time of a scheduled hearing, avoid requesting a postponement for a conflict that arises late.

**78. If I have a child and go to an Administrative Law Judge hearing, what should I do?**

WHEN REPRESENTING A CHILD, BE PREPARED TO HAVE SOMEONE AVAILABLE TO LOOK AFTER THE CHILD, IF POSSIBLE, AFTER HE OR SHE TESTIFIES OR DOES NOT TESTIFY. Representatives should avoid keeping the child in the hearing room when it will disrupt the hearing process or is otherwise not appropriate.

**79. I have heard that I can have my case expedited by agreeing to a video hearing. Should I have my case heard by videoconference by a judge who does not preside in my home jurisdiction or court?**

You have the absolute right for your case to be heard live by a judge in your home state and jurisdiction. We know that you have been waiting for quite some time to have your case adjudicated, but we firmly advise against your case being heard by an out of state judge via a video link.

Technical difficulties aside, we advise against such hearings. Studies (especially those done by Stanley Milgram, et. al., at Yale and the progenies of those studies) have shown that persons who are outside of the actual physical presence of someone who can determine their reward or punishment are more likely to have negative results applied to their persons when they are not actually physically present with them. Though it may be apparent to you that a judge wants to help with your appeal by agreeing to hear your case by video link out of state or out of jurisdiction, from our experience these non-live hearings result in fewer favorable decisions and result in more lengthy appeals to the Appeals Council in Falls Church, Virginia after a disability video hearing. This, thereby extends the years one will have to eventually wait for his or her Social Security Disability/SSI benefits.

By way of example, a video hearing is inadequate to show a judge how a claimant's cane handle may be well used or the end worn down. In a video conference it is impossible to convey a claimant's depression or full credibility to a judge via the video link, no matter how good that link is. More importantly, the video-judge will probably not know of our firm's well-earned reputation that the judges we regularly appear before have of us or of our appellate record reversing judges' denials of benefits. By choosing to have your hearing heard via video link with all its setbacks, one in essence gives this up and loses not only the "home field advantage" but his or her rights to a live hearing and a higher chance of winning their case. We advise against it. Even though it may be tempting, and though relief may seem to be closer, the chances of success are illusory at best and lessened.

**80. What sort of place is the actual office where my case will be heard?**

Your case will be heard in a hearing room. This room is usually about 14 feet wide by 20 feet long. An ALJ will be presiding at the head of the room and there will be a hearing monitor who will assist the ALJ in taking your testimony down. There may be a Vocational Expert there who will listen to your testimony and give expert opinions on your employability in a competitive national labor market. There may also be an expert Medical Evaluator to consider your medical records, testimony and symptoms to render an opinion as to whether you meet a Medical Listing or can do certain tasks that impact on your employability.

**81. What should I do after an Administrative Law Judge hearing?**

The following are suggestions for proceeding after your hearing is complete.

1. SUBMIT POST-HEARING EVIDENCE AS SOON AS POSSIBLE WITH A WRITTEN BRIEF IDENTIFYING HOW THE EVIDENCE SUPPORTS A FAVORABLE DECISION. This will assist the ALJ in reviewing the records and appropriately focus attention on the information supporting your arguments and result in the issuance of a timely decision.

2. WHENEVER POSSIBLE, YOUR ATTORNEY SHOULD SUBMIT FEE PETITIONS WITHIN 60 DAYS OF A DECISION OR AS SOON AS POSSIBLE AFTER SERVICES HAVE BEEN TERMINATED OR WITHDRAWN. Submitting fee documents within this time frame will have a significant impact on the time a representative waits for payment. This reduces the number of follow-ups necessary to determine if a fee petition is going to be submitted and allow the ALJ to act on the fee authorization at an earlier date. It reduces the likelihood that funds withheld for direct payment will be released to the claimant and reduces the wait time if administrative review of an authorized fee is requested.

**82. This sounds complicated. What about my right to representation in my disability case?**

You can have a representative, such as an attorney or licensed non-attorney representative to help you when you do business with Social Security. SSA will work with your attorney/representative just as they would with you.

For your protection, your representative cannot charge or collect a fee from you without first getting written approval for SSA. However, your representative may accept money from you in advance as long as it is held in a trust or escrow account.

Both you and your representative are responsible for providing SSA with accurate information. It is illegal to furnish false information knowingly and willfully. If you do, you may face criminal prosecution. That is why you need to complete your paperwork TRUTHFULLY for your attorney to submit.

**83. What if a claimant dies while his or her claim is pending before the Social Security Administration?**

If a claimant dies while the claim is pending, his or her spouse or child, parent, Administrator/Executor of the estate or other related person will have to file a "Notice Regarding Substitution of Party Upon Death of Claimant" or Form HA-539 with the SSA. This will notify the SSA of the death and their wish to pursue the claim on behalf of themselves, relatives or the estate. This may be important when there are back due benefits or large medical bills which can be paid by Medicare, should the deceased claimant be found disabled. This later case is especially true when the disabling condition is the actual cause of death cited in the claimant's death certificate. So, if you can, you should get a copy of the death certificate with the cause of death noted. In most states, a death certificate with the cause of death included must be asked for specifically as the specific cause of death is customarily left off.

# SOCIAL SECURITY DISABILITY CLAIM ADJUDICATIONS

**83. Is Getting SSDI or SSI just a matter of luck or is there a framework that the judge must use in determining whether or not a claimant is disabled?**

Yes, it can be a matter of luck. Judges are drawn at random essentially. You may not even know who your judge will be until the day of your hearing. However, there is a legal framework for the ALJ to use in deciding if you are disabled or not. The following sets forth that framework.

**84. What is the Statutory or Legal Framework for Considering a Social Security Disability Claim?**

The framework that the Social Security Administration will follow is found below. It is a five-step process that consists of the following steps.

Step 1. Does the claimant presently or did her/she during period of disability earn wages of $1040 or more?

At step one the ALJ must determine whether the claimant is engaging in substantial gainful activity (20CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. If an individual engages in

SGA, that individual is not disabled regardless of how severe that individual's physical or mental impairments are and regardless of age, education, and work experience. If an individual is not engaging in SGA, the analysis proceeds to the second step.

Step 2. Is there anything medically wrong with the claimant that interferes with his/her ability to work?

At step two, the ALJ must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits the individual's ability to perform basic work activities. If the claimant does not have a severe medically determinable impairment or combination of impairments, the claimant is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

Step 3. Does any or do several of the impairments meet a listing?

At step three, the ALJ must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526(d), 416.925, and 416.909). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR Part 404, Subpart P. Appendix 1 (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

Step 4. What is the claimant able and not able to do, given his/her mental and physical limitations?

Can he/she do his/her past jobs? Past jobs go back 15 years from the onset date and only jobs that the claimant did long enough to be able to master them. A simple job generally does not take long to master (a few months), while a complex one does.

Before considering step four of the sequential evaluation process, the ALJ must first determine the claimant's residual functional capacity (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is the individual's ability to do physical and mental work activities on a substantial basis despite limitations from the individual's impairments. In making this finding, the ALJ must consider all of the claimant's impairments, including impairments that are not severe. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p)

Next, the ALJ must determine at step four whether the claimant has the residual functional capacity to perform the requirements of the claimant's past relevant work (20 CFR 404.1520(f) and 416.920(f)). If the claimant has the residual functional capacity to do the claimant's past relevant work, the claimant is not disabled. If the claimant is

unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

Step 5. In light of the residual functional capacity described above, since the claimant cannot do his/her past work, what jobs can the claimant perform?

This area concerns vocational expertise. If a claimant has past relevant work in a given extertional category, then to get disability benefits, the claimant must not be capable of performing work in that extertional category given his/her age, education and work experience. There are definitions for physical exertional categories and they apply whenever the claimant has a physical impairment. The code of federal regulations (CFR) 20 CFR §416.967 describes these physical exertion requirements as follows:

Physical exertion requirements:

To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

(a) Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

(b) Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

(c) Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

(d) Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

(e) Very heavy work. Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work.

Generally, but not always, to get disability a person, whose condition does not meet a listing must show that he/she is not capable of performing a sedentary work on a full time basis. Older people, those 50 and over, may be able to get benefits with the ability to work at light levels, depending on age, education, and work history and whether they learned any skills that could be used in other jobs (referred to as transferability of job skills).

Mental impairments limitations:

These impairments consider a completely different set of circumstances. The CFR describes the limitations generally as follows: "A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work." 20 C.F.R. §404.1545(c). The various limitations described in the mental residual functional capacity questionnaires address these limitations. The ability to function in the following categories is weighed: 1) activities of daily living (grooming, getting to and from work, ability to shop for food, maintain a household); 2) social functioning (ability to get along and interact with people) 3) concentration, persistence and pace (ability to pay attention to work instructions and requirements); 4) episode of decompensation (hospitalizations, times when person is unable to leave home due to mental illness). An important factor for many claimants is the ability to maintain concentration, persistence and pace, but all factors should be considered.

At the last step of the sequential evaluation process (20 CRF 404.1520(g) and 416.920(g)), the ALJ must determine whether the claimant is able to do any other work considering the claimant's residual functional capacity, age, education and work experience. If the claimant is able to do other work, the claimant is not disabled. If the claimant is able to do other work and meets the duration requirement, the claimant is not disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 404.1512(g), 404.156(c), 416.912(g), and 416.960(c)).

**85. Will the ALJ give me a decision immediately after my hearing?**

Rarely. Some decisions called "Bench Decisions" are issued by the ALJ while he or she is still sitting on the bench before you. This occurs in fewer than ten percent of cases heard before an ALJ. One must have a particularly convincing case or advocate to help make this happen.

**86. So, typically, what happens after the hearing, and how will the decision be rendered?**

After your case is heard, the judge will make his or her decision and enter a written Order either granting or denying your benefits.

**87. Does the ALJ's decision have to be in writing?**

Yes. A judge's decision is not final until written notice is sent.

**88. Can I talk with anyone at the judge's office while the decision is pending?**

Probably not. Unless you are trying to provide additional evidence, you should not contact the ALJ's office. The ALJ and the ALJ's office will not speak with you over the telephone prior to a claimant's receipt of a written decision.

**89. How long will I usually have to wait to receive a written Order from the ALJ?**

The ALJ will usually make his or her decision shortly after the hearing, providing that there is no additional evidence or Consultative Evaluations that have been requested. The judge's decision is then written, typed, corrected and finally signed by the ALJ. This process usually takes between two and six weeks. You will probably receive written notice during that time.

**90. What if, after my case is heard by an ALJ, I receive a "Notice of Decision-Unfavorable"?**

That is notice that you have lost at your hearing. If you lose at your hearing either, in full or in part, and do not agree with the ALJ's decision, you must file a timely appeal with the "Appeals Council"

How many days after I receive my unfavorable or partially favorable NOTICE OF DECISION do I have to file my appeal?

Within 60 days of the date you get your NOTICE OF DECISION, you must file your appeal. The Appeals Council assumes you received the NOTICE OF DECISION 5 days after the date shown on that notice unless you can show that you did not get it within the 5-day period. The Appeals Council will dismiss a late request unless you show good cause for not filing it on time.

## APPEALS AFTER YOUR ALJ HEARING

**91. What if I lose at my hearing, what next?**

If you lose your case at a hearing before an administrative law judge, you will have 60 days from the date to receive your "Notice of Decision-Unfavorable" in which you can appeal to the Social Security Administration and the Appeals Council in Fall's Church Virginia.

**92. What happens at the Appeals Council?**

At the Appeals Council, you will have the opportunity to write and set forth the reasons why you or your attorney think the appeals administrative Law judge was wrong in not granting you your benefits. Then a panel of judges will look at the evidence in your case to determine whether the ALJ made a significant legal or factual decision in denying you your benefits.

**93. Can I file additional medical documentation that was not available when the ALJ heard my case, so that the Appeals Council can consider it?**

Yes; as long as the Appeals Council has not made its decision in writing, you may submit additional evidence. It needs to be evidence that was not in the court's record at the time of your hearing or submitted subsequent to your hearing that was not addressed or considered by the court in its decision after your hearing

**94. If I am denied my benefits, how long do I have to appeal my case to the Appeals Council?**

You will have 60 days from the receipt of your "Notice of Decision- Unfavorable to file your appeal to Falls Church Virginia where the Appeals Council sits.

**95. What grounds can a Claimant assert as the basis of error committed by the ALJ?**

There are many grounds upon which an ALJ may be reversed. Often, with unrepresented claimants, the claimant will not know what questions to ask, and, as responsive as an ALJ may be to an unrepresented claimant, the judge is not in the best position to know how your case should be presented. So, error can and may occur.

**96. When I think that an ALJ did not adequately consider my pain, what would be grounds for me to assert on appeal?**

You might want to assert, for example that "The ALJ failed to properly evaluate the claimants subjective complaints of pain and dysfunction that can reasonably be accepted as consistent with the objective medical evidence and provide adequate rationale in accordance with disability regulations pertaining to evaluations of symptoms based on the requirements of 20 CFR 404.1529 and 416.929 and Social Security Ruling 96-7 p." (You may refer to the Appendix below in this section or elsewhere on this website where these laws, References and Social Security Rulings, SSRs, appear.)

You may also decide to assert that "The ALJ failed to properly evaluate and consider the location, duration, frequency, and intensity of pain and other symptoms" as a basis for your appeal.

**97. What if the ALJ did not consider or address the side effects of my medications on my employability?**

An ALJ must consider both precipitating and aggravating factors of your disability and the type, dosage, effectiveness, and side effects of medications. So, you may want to say that "The ALJ failed to properly evaluate and consider both precipitating and aggravating factors of my disability and the type, dosage and effectiveness of my medications."

One might also allege that "The ALJ erred in failing to take into account the effect of medications on Claimant's residual functional capacity in determining disability, in violating of SSR 96-7."

**98. What if the ALJ fails to consider my need for medical care and treatment that will occur on a regular basis, or the absences I will probably have for this medical care or just being too sick to work a few days or more per month due to my sickness?**

The ALJ must consider these things in his or her decision. You may want to assert that "The ALJ failed to consider the claimant's need to accommodate his/her physical and/or mentally related symptoms, need for medical treatment and absences related to symptoms and/or medical treatment."

**99. What if I feel that the ALJ did not really pay attention to what my own doctors had to say about my illness?**

You might want to state that "The ALJ failed to give proper consideration and weight to the records and opinions of treating sources pursuant to Provision of 20 CFR 404.1527 and 416.927 and Social Security Rulings 96-2p and 96-5p and 96-6p and adequately explain the weight given to such opinion evidence."

"The ALJ failed to consider additional medical records submitted to the ALJ prior to the entry of the ALJ's decision in this case." Or "The ALJ erred in failing to accord adequate weight to the opinion of my treating physician." Or "The ALJ erred in improperly discounting the opinions of my treating physician Dr. _____ stating without basis in fact or reason as to how or why the treating physician's opinions appear to rest at least in part on an assessment of an impairment(s) outside the doctor's area of expertise and were rendered less than persuasive," or "The ALJ erred in not finding Dr. _____'s opinions persuasive stating without basis in fact or reason that the opinions appeared to be internally inconsistent."

**100. What if the judge disregarded the RFC form that my doctor filled out for me that I think says I am disabled?**

You might want to state that "The ALJ failed to give proper consideration and weight to the records and opinions of treating sources pursuant to Provision of 20 CFR 404.1527

and 416.927 and Social Security Rulings 96-2p and 96-5p and 96-6p and adequately explain the weight given to such opinion evidence." or

"The ALJ failed to consider additional medical records submitted to the ALJ prior to the entry of the ALJ's decision in this case." Or "The ALJ erred in failing to accord adequate weight to the opinion of my treating physician." Or "The ALJ erred in improperly discounting the opinions of my treating physician Dr. _____ stating without basis in fact or reason as to how or why the treating physician's opinions appear to rest at least in part on an assessment of an impairment(s) outside the doctor's area of expertise and were rendered less than persuasive," or "The ALJ erred in not finding Dr. _____'s opinions persuasive stating without basis in fact or reason that the opinions appeared to be internally inconsistent."

**101. What if the Vocational Expert (Evaluator) at my hearing was never asked by the ALJ about the limitations put on by my own doctor or that from other doctors who either evaluated me for the SSA or reviewed my file?**

The hypothetical questions framed by the ALJ must reflect the record as a whole. A judge cannot "cherry-pick" from the record, so if that is what you believe that the judge did you may assert that "the questions framed by the ALJ did not reflect the specific capacity/limitations established by the record as a whole."

Or "The ALJ erred in failing to develop the record by not contacting the treating physician to request additional evidence and/or clarification regarding claimant's impairments or residual functional capacity, as requested by 20 C.F.R. '404.1512(e)."

Or "The ALJ failed to develop the record, in that _____" (Insert the basis you feel is appropriate).

Or "The ALJ failed to properly evaluate the evidence and adequately explain the conflicts in the evidence, and why greater weight was given to one source as opposed to others which would have adequately supported an award."

**102. What if there was plenty of evidence on my behalf that outweighed the evidence that was of record against my being found disabled?**

An ALJ must adequately weigh the evidence and explain the conflicts in the evidence and resolve them. If you feel that this happened to you may want to allege in your appeal that "The ALJ's denial of benefits was against the greater weight of the evidence and is not adequately supported by the evidence of record."

I think that the ALJ called me a liar, in essence, because he just did not believe my testimony and did not explain why he/she felt I was less than fully credible. How do I appeal that?

The ALJ must adequately assess your credibility and state reasons why he believed or disbelieved you at your hearing. If you think that that happened, you may assert in your appeal that "The ALJ failed to adequately assess or evaluate my credibility."

**102.a. What if I am indigent or without adequate funds or insurance to pay for my medical care, is that a grounds that an ALJ must consider in denying my benefits?**

Yes. An ALJ cannot just deny you benefits because you have had no medical care as a result of poverty or other circumstances outside of your control. For example, if you think the ALJ was unreasonable in not sending you out to be medically examined by a doctor on the SSA list, you may allege that "The ALJ erred in not having me evaluated medically by a medical doctor."

Or "The ALJ erred in failing to comply with SSR 96-7p in discrediting claimant for claimant's failure to obtain treatment without considering claimant's valid and undisputed reason of lack of funds."

**102.b. What if the judge wrongly decided I could go back to medium work when all I can do is light work or sedentary work?**

You may want to state in your appeal that "The ALJ's decision that the claimant can do "medium" duty work is not supported by the evidence of record and ignores uncontroverted evidence of record by Dr._____ (insert record evidence) and/or treating physicians that place the claimant at a "light' duty exertional capacity or less which, based on the claimant's age, education, transferable job skills or lack there of would mandate a finding of disabled pursuant to Pt 404, Sub Pt. P, App.2, 201-202. Or "The ALJ has failed to adequately articulate the bases for finding the claimant capable of medium duty work or for accepting the opinions of evaluating or non evaluating sources over those whom are considered "treating" sources concerning the claimant's residual physical or psychological ability to engage in full-time employment."

**103. What if my pain or depression prevents me from concentrating on simple one or two-step tasks throughout the day, is that something the ALJ has to consider if I testify about it or my doctors have written about this and those reports are in the record?**

The ALJ must take into consideration any deficits you may have in memory, focus, concentration, persistence or pace. If you testify about this, or if the physicians have written about this, and it is part of your record, you should probably allege that "The ALJ erred in failing to take into account my limitations in the ability to maintain attention,

concentration, and pace in assessing my residual functional capacity." Or "The ALJ failed to properly assess my RFL by failing to properly posit appropriate hypotheticals to the VE."

**104. If I suffer from obesity and it is not my primary disabling condition, must the ALJ consider the effects of obesity on my residual physical capacity in determining if I am disabled or not?**

An ALJ must consider obesity and its overall impact on your ability to work. If the ALJ failed to take your obesity into consideration you may want to allege that "The ALJ failed to take into consideration the claimant's obesity and its effects on the claimants Residual Functional Capacity."

**105. If a Vocational Expert testifies in my case and says that the jobs he thinks I can do are not listed in The Dictionary of Occupational titles or are not consistent with that book, how do I appeal that?**

If the Vocational Expert testified that you, the claimant, could return to a job that had no D.O.T. number, you may state that: "The VE's testimony was not consistent with the Dictionary of Occupational Titles and was not a competent substantial basis upon which the ALJ's opinion should have been based."

**106. Is there anything else I should put into my appeal to The Appeals Council?**

Yes.
You may want to include the following language in your appeal:

"Based on the foregoing and arguments accompanied herewith, the claimant specifically requests the Appeals Council to consider the entire case to determine whether review should be granted pursuant to 20 C.F.R.' 404.970(a). The foregoing list of errors is not exhaustive and only represents the more significant errors upon which the Appeals Council could readily determine that remand or reversal is required. The Appeals Council is required to evaluate the entire case to determine if any other basis for granting review exists as set forth by 20 C.F.R. ' 404.970(a). If the Appeals Council does intend to limit its review to only those issues specifically raised herein, the claimant hereby requests specific notice of such intent as well as the opportunity to submit additional arguments within 30 days of receipt of such notice."

And "Based on the foregoing, the claimant respectfully requests that the Appeals Council reverse the ALJ's decision and award benefits. Alternatively, the Appeals Council should remand this matter for further proceedings as set forth herein."

**107. What does an appeal look like?**

Your appeal is commonly called a "Request for Review." It is also known as form HA-520. You may also write a letter setting forth the basis of your appeal.

**108. Are there any special forms that I need to use to appeal my case to the Appeals Council?**

Yes. You will need to obtain and file a "Request for Review of Hearing Decision/Order," FormHA-520-US (5-2003) ef (05-2005) from the Social Security Administration.

**109. What form do I have to complete and file to do this again, and do I have to include my most recent address and my Social Security Number?**

You will have to file form HA-520-U5 also known as a "Request for Review of Hearing Decision/Order" with all updated information along with your Social Security Number.

**110. To where do I send it?**

The form must be sent to:
Appeals Council
Office of Hearings and Appeals,
Social Security Administration
5107 Leesburg Pike
Falls Church, VA 22041-3255

**111. How and when do I send it?**

You must send your "Request for Review of Hearing Decision/Order" certified mail return receipt requested preferably, within 60 days of receiving your unfavorable decision from the ALJ.

**112. What do you advise with actions before the appeals council?**

The Appeals Council will tell you the following, all of which is considered pretty much standard practice. Follow these cardinal rules, and you should have no problems procedurally.

1. IF REQUESTING A COPY OF THE RECORD, SUBMIT A CLEAR REQUEST. The request should be clearly stated at the beginning of your correspondence to facilitate the Appeals Council support staff screening and action on your request.

2. SUBMIT ANY ADDITIONAL EVIDENCE OR COMMENTS WITH THE REQUEST FOR REVIEW. For internal review and association purposes, submitting all evidence at the same time would be very helpful.

3. IF YOU HAVE ADDITIONAL EVIDENCE, EXPLAIN HOW IT IS MATERIAL TO THE PERIOD AT ISSUE. In regard to new evidence, the Appeals Council applies 20 CFR §§ 404.970 and 416.1470.

4. CONTENTIONS SHOULD BE SPECIFIC. It is always good practice to concisely focus your arguments for a reviewer. We recommend using 2,000 words or less if possible.

5. CONTENTIONS DO NOT NEED TO INCLUDE A RECITATION OF THE JURISDICTIONAL HISTORY OR EVIDENCE GENERALLY, UNLESS RELATED TO A SPECIFIC POINT OF CONTENTION. The record is already before the Appeals Council.

6. CITE TO THE RECORD. Include pages numbers of exhibits.

7. DO NOT MAKE AUTOMATIC, MULTIPLE REQUESTS FOR THE STATUS OF A REQUEST FOR REVIEW. You can verify that the Appeals Council has received the request through your local Social Security office, local hearing office or by calling the Congressional and Public Affairs Branch staff (1-703-605-8000) or the general inquiries staff at the toll-free telephone number (1-800-772-1213).

8. BE SPECIFIC IN REQUESTING AN EXTENSION OF TIME. Requests for extension of time should explain how much additional time is needed and why the request should be granted.

### 113. What will the Appeals Council do if I am successful?

They will review your appeal and decide what mistakes the ALJ made and how to correct them. Then they will send the case back to the ALJ to follow the orders of the Appeals Council, and most likely you will have another hearing to correct the earlier ALJ's mistakes.

### 114. What if I lose at Appeals Council?

If you lose at Appeals Council, you will have to appeal your case to the federal District Court in the jurisdiction in which your case was decided by the ALJ. This is a

complicated matter and will require the services of an attorney who specializes in this kind of work.

### 115. What are some grounds for overturning an Appeal's Council decision denying me benefits?

There are many bases upon which an ALJ's ruling may be appealed after your Appeals Council Denial. Much like those with the Appeals Council, the following is a categorical list and is in no way exhaustive, but it does set forth many of the common mistakes made by administrative law judges. You will need citations to the trial record and cases from US federal courts that support your positions. This is a task best left to an attorney. However, here are some areas where reversal is commonly granted.

CREDIBILITY

The ALJ failed to adequately assess or evaluate the claimant's credibility.

The ALJ found that the claimant's medically determinable impairments could reasonably be expected to cause the alleged symptoms; however, without saying exactly why and without adequate explanation, the ALJ erred when he/she concluded that "the claimant's statements concerning the intensity, persistence, and limiting effects of these symptoms are not credible to the extent they are inconsistent with the above residual functional capacity assessment."

The ALJ failed to make a proper credibility finding. The ALJ committed reversible error in failing to comply with SSR 96-7p and 20 C.F.R. § 404.1529 in evaluating the claimant's subjective complaints.

The ALJ failed to properly evaluate the claimant's subjective complaints of pain and dysfunction that can reasonably be accepted as consistent with the objective medical evidence and provide adequate rationale in accordance with disability regulations pertaining to evaluations of symptoms based on the requirements of 20 CFR 404.1529 and 416.929 and Social Security Ruling, 96.4 p and 96-7 p.

The ALJ erred in failing to comply with SSR 96-7p in discrediting claimant for claimant's failure to obtain treatment without considering claimant's valid and undisputed reason of lack of funds.

The ALJ erred in failing to accord adequate weight to the opinion of claimant's treating physician.

The ALJ failed to give proper consideration and weight to the records and opinions of treating sources pursuant to Provision of 20 CFR 404.1527 and 416.927 and Social Security Rulings 96-2p and 96-5p and 96-6p and to adequately explain the weight given to such opinion evidence.

The ALJ failed to address other medical opinions of record.

The ALJ committed reversible error in failing to provide any reason whatsoever for rejection of the opinion of a treating physician whose opinion directly conflicts with the ALJ's RFC finding.

The ALJ erred in improperly discounting the opinions of the claimant's treating physician, stating without basis in fact or reason as to how or why the treating physician's opinions appear to rest at least in part on an assessment of an impairment(s) outside the doctor's area of expertise and were rendered less than persuasive.

The ALJ erred in not finding a treating doctor's opinions persuasive. The ALJ opined, stating without basis in fact or reason that the opinions of the claimant's treating physician appeared to be internally inconsistent.

The ALJ failed to address treating physician evidence. While the ALJ referenced the opinion of the treating physician, the ALJ failed to comply with 20 C.F.R. § 404.1527 in not providing any reasons whatsoever for his/her obvious rejection of this opinion.

The ALJ failed to address opinion(s) of State agency non-examining medical consultants. The ALJ failed to comply with 20 C.F.R. § 404.1527(f)(2) in ignoring the opinion of the State agency non-examining physician and in failing to provide any reason for his obvious rejection of this evidence.

RESIDUAL FUNCTIONAL CAPACITY

The ALJ failed to properly evaluate the evidence and to adequately explain the conflicts in the evidence, and why greater weight was given to one source as opposed to others that would have adequately supported an award.

The ALJ has failed to adequately articulate the bases for finding the claimant capable of sedentary or light duty work or for accepting the opinions of evaluating or non evaluating sources over those sources that are considered "treating" sources concerning the claimant's residual physical or psychological ability to engage in full-time employment.

The ALJ failed to give adequate consideration to the claimant's maximum RFC and provide adequate rationale with specific references to evidence of record to support the assessed limitations (20 CFR 404.1545 and 416.945 and Social Security Ruling 85-16 and 96-8p).

Therefore, the ALJ failed to properly assess the claimant's RFC. The ALJ committed reversible error in failing to comply with SSR96-8p in assessing the claimant's RFC.

The ALJ's decision that the Claimant can do sedentary or light duty work is not supported by the evidence of record and ignores uncontroverted evidence of record by state agency medical consultants and/or treating physicians that place the Claimant at a "light" duty exertional capacity which based on the Claimant's age, education, transferable job skills, or lack thereof, would mandate a finding of disabled pursuant to Pt 404, Sub Pt. P, App.2, 201-202.

The ALJ's denial of benefits was against the greater weight of the evidence and is not adequately supported by the evidence of record.

PAIN

The ALJ failed to properly evaluate and consider the location, duration, frequency and intensity of pain and other symptoms; precipitating and aggravating factors and the type, dosage, effectiveness, and side effects of medications and the claimant's other needs to accommodate his/her physical and/or mentally related symptoms, need for medical treatment, and absences related to symptoms and/or medical treatment. The ALJ failed to develop the record.

The ALJ erred in failing to develop the record by not contacting the treating physician to request additional evidence and/or clarification regarding claimant's impairments or residual functional capacity as required by 20 C.F.R. '404.1512(e).

The ALJ made a mischaracterization or misstatement of the record in a significant respect as follows:

The ALJ failed to consider additional medical records submitted to the ALJ prior to the entry of the ALJ's decision in this case.

The ALJ erred in failing to take into account the effect of medications on claimant's residual functional capacity in determining disability in violating of SSR 96-7.

MENTAL IMPAIRMENTS

The ALJ failed to properly evaluate mental impairment(s). The ALJ erred in failing to evaluate the claimant's mental impairment and resulting functional limitations as required by 20 C.F.R. § 404.1520a.

The ALJ erred in failing to take into account claimant's limitations of moderate limitation in ability to maintain attention, concentration, and pace in assessing Claimant's residual functional capacity through questioning of the vocational expert.

RELEVANT WORK

The ALJ failed to properly consider the mental and physical demands of the claimant's past work. The ALJ failed to obtain vocational expert testimony. The ALJ committed reversible error in mechanically relying on the Medical-Vocational Guidelines and in failing to obtain Vocational expert testimony.

The ALJ failed to properly consider the mental and physical demands of the claimant's past work. The ALJ committed reversible error in failing to comply with SSR82-62 in not discussing the specific mental and physical demands of the claimant's past relevant work prior to summarily determining that she/he can return to that work.

OBESITY

The ALJ failed to take into consideration the claimant's obesity and its effects on the Claimants Residual Functional Capacity.

VOCATIONAL EXPERTS

The ALJ failed to obtain vocational expert testimony. The ALJ committed reversible error in mechanically relying on the Medical-Vocational Guidelines and in failing to obtain vocational expert testimony.

The Vocational Expert testified that the Claimant could return to a job that had no D.O.T. number. As such, the VE's testimony was not consistent with the Dictionary of Occupational Titles and was not a competent substantial basis upon which the ALJ opinion should have been based.

The hypothetical questions framed by the ALJ did not reflect the specific capacity/limitations established by the record as a whole.

POST HEARING

The ALJ failed to comply with the HALLEX procedures in soliciting post-hearing evidence. The ALJ failed to comply with procedures set for in HALLEX I-2 5-42 in failing to transmit the proposed interrogatories to claimant prior to submission to the physician or in failing to proffer the new evidence to the claimant.

JUST PLAIN WRONG

The ALJ erred in reaching the ALJ's Decision without fact or reason that the opinion of the treating physician were obtained through attorney referral and in connection with an effort to generate evidence for the current appeal. This was not in an attempt to seek treatment for symptoms as also the doctor was presumably paid for the reports a context in which (this evidence) was produced cannot be entirely ignored.

### 116. What if I cannot afford to pay the filing fees to the Federal District Court?

You can file an Affidavit to Proceed in Forma Pauperis, and if you are found indigent, the Federal Court will waive your filing costs.

## REPRESENTATION

### 117. Should I hire an attorney or someone to represent me to handle my Social Security Disability claim?

As a general rule, a person does not need a lawyer to help to file an application. After the application is filed, however, an experienced lawyer's or licensed representative's help may make the difference between winning and losing your case. This is true even at the initial application stage. The SSA allows non-attorneys to represent claimants. These non-attorneys are also regulated and subject to Professional and Disciplinary Standards just as Licensed Attorneys are and can represent you through the Appeals Council stage. Thereafter only a properly licensed attorney can handle your case from initial filing through hearing and appeal into Federal District Court and Circuit Courts of Appeal and into the United States Supreme Court if necessary.

**118. What can an attorney or representative do for me?**

Once you appoint an a licensed attorney or representative, he or she can act on your behalf in most Social Security matters by:

* Getting information from your Social Security file;
* Helping you get medical records or information to support your claim;
* Coming with you, or for you, to any interview, conference, or hearing you have with SSA;
* Requesting a reconsideration, hearing or Appeals Council review; and
* Helping you and your witness prepare for a hearing and questioning any witnesses.

Your representative also will receive a copy of the decision(s) SSA makes on your claim.

**119. How much can my attorney/representative charge me?**

Attorney's fees are limited to 25% of the award of your past due benefits. That is one-fourth of those benefits that build up by the time you are found disabled, and benefits are paid. Fees are also capped administratively, presently at $6,000.00 with the Social Security Administration, so the cap can be even less than 25% of past due benefits or the statutory cap, whichever is the lesser of the two.

**120. What about costs?**

In addition to the fee, your representative may charge you for the expenses of gathering medical records, obtaining medical opinion letters, etc. Costs rarely run over $450.00, and if we are unsuccessful in obtaining your disability benefits for you, you will not owe us for either costs or fees for the time we spend on your behalf.

**121. Can you tell me more about the costs of prosecuting my claim and how I may pay?**

The amount of the fee the SSA decides your representative may charge is the most you owe for his or her services, even if you agreed to pay your representative more. However, your representative can charge you for out-of-pocket expenses, such as the medical report, without your approval. These expenses are not paid to your attorney by the SSA or deducted from your reward.

If an attorney or non-attorney whom Social Security has found eligible for direct payment represents you, the SSA usually withholds 25% (but never more) of your past-due benefits to pay towards the fee. The SSA pays all or part of the representative's fee from this money and sends you any money left over.

Sometimes you must pay your representative directly:
*your representative is not eligible for direct payment;
*the SSA did not withhold 25% from your past-due Social Security or Supplemental Security Income Benefits or both; or
*your representative made a timely request for a fee, and the SSA sent you the money that the SSA should have withheld.

You must pay for the out-of-pocket expenses that your representative incurs or expect(s) to incur (for example, the cost of getting your doctor's or hospital records, etc.). At the Law Offices of Mike Murburg P.A., we will pay these reasonable costs in advance for you. We ask for reimbursement only if you win.

**122. Can someone else pay my attorney?**

Even when someone else will pay the fee for you (for example, an insurance company), the SSA must approve the fees unless:

*it is a nonprofit organization or federal, state, county, or city agency that will pay the fee and any expenses from government funds; and
*your representative gives the SSA a written statement that you will not have to pay any fee or expenses. At our Law Offices at Mike Murburg P.A., we work for the disabled client, not the government or insurance company, and no fee or expense is due while your case is pending. Your costs are payable only if you win.

**123. How does my representative or attorney get to charge me?**

To charge you a fee for services, your attorney or representative first must file either a fee agreement or a fee petition with the SSA.

Your representative cannot charge you more than the fee amount the SSA approves. If you or your representative disagree with the fee the SSA approves, either of you can ask the SSA to look at it again.

A representative who charges or collects a fee without the SSA's approval or charges or collects too much, may be suspended or disqualified from representing anyone before the Social Security Administration and also may face criminal prosecution.

**124. Does the fee for my representative have to be in writing and approved by the Social Security Administration?**

The agreement must be in writing and be approved by the Social Security Administration. For your protection, your representative cannot charge or collect a fee from you without first getting written approval for SSA. However, your representative may accept money from you in advance as long as it is held in a trust or escrow account.

**125. What do I do about getting a fee agreement?**

If retained, your attorney will file all the necessary paperwork for you. If you and your attorney/representative have a written fee agreement, your representative may ask the SSA to approve it any time before SSA decides your claim. Usually, the SSA will approve the agreement and tell you in writing how much your representative may charge as long as:
* you both signed the agreement;
* your claim was approved and resulted in past due benefits; and
* the fee you agreed on is no more than 25% of past-due benefits or $6000.00, whichever is less.

If the SSA does not approve the fee agreement, the SSA will notify you and your representative in writing that your representative must file a fee petition.

**126. What is a fee petition?**

Your representative may give the SSA a fee petition after completing the work on your claim(s). This written request should describe in detail the amount of time spent on each service your representative provided. Your representative must give you a copy of the fee petition and each attachment. If you disagree with the fee requested or the information shown, contact the SSA within 20 days. The SSA will consider the reasonable value of representative's services and tell you in writing the amount of the fee the SSA will approve.

**127. Will the fee come out of my future monthly benefits?**

Absolutely not; fees are paid based on past benefits won for a claimant unless the Social Security Administration does not deduct them, and you receive them and spend the fees that were to be sent to your attorney. Otherwise under no circumstances do fees come out of current monthly benefits.

**128. How should I choose an attorney or somebody to represent me?**

You can choose an attorney or other qualified person to represent you. You also can have more than one representative. However, you cannot have someone who has been suspended or disqualified from representing others before the Social Security Administration or who may not, by law, act as a representative. Attorneys who have active licenses can represent you but check on their experience and record. Some organizations can help you find an attorney or give your free legal services if you qualify.

**129. What can I do if I want to obtain a private attorney to represent me but I have been unable to find one?**

If you do not choose to have us represent you or you want to find another attorney or representative, a private attorney may be obtained by contacting the organization shown below. You will be referred to a private practicing lawyer who is familiar with representing claimants before the Social Security Administration, like we do at Mike Murburg P.A.. Some private attorneys may be willing to take your case under a fee agreement whereby no fee will be charged unless your claim is allowed. The attorney must first obtain approval from the Social Security Administration for any fee charged. For help in obtaining a social security attorney in your area contact the National Organization of Social Security Claimants Representatives (NOSSCR), 6 Prospect Street, Midland Park, NJ 07432, tel. 800-431-2804.

The attorneys at the Law Offices of Mike Murburg P.A. are members of NOSSCR.

**130. Can I have more than one representative?**

You can appoint one or more people in a firm, corporation, or other organization as your representative, but you may not appoint the firm, corporation, or organization itself.

**131. When should I contact an attorney or someone to represent me?**

As a general rule it is better to contact an attorney earlier rather than later.

**132. How will Social Security know if I am being represented or not?**

After you choose a representative, you or your attorney must tell SSA in writing as soon as possible. To do this, get Form SSA-1696-U4, Appointment of Representative, from the SSA website ( www.socialsecurity.gov ) or from any Social Security office. We take care of this detail for you once we are retained, otherwise you must give the name of the person you are appointing and sign your name. If the person is not an attorney, he or she must give his or her name in writing and state that he or she accepts the appointment by signing the form.

**133. How often should I meet with my attorney or representative during my case?**

The attorneys at the Law Offices of Mike Murburg, P.A. are all well seasoned trial attorneys whose skills, much like those of a skilled surgeon, are honed by trying numerous cases on a weekly basis. Like a heart, eye, or neurosurgeon, you will meet your attorney initially, then for a pretrial (surgical) preparation, and then just before and during the trial (surgery).

At the Law Offices of Mike Murburg, P.A. you will be interviewed by an attorney at the onset of your case. That attorney will be the one whose staff will be in charge of your file.

When your case gets to the hearing stage, our staff will send you an extensive questionnaire that you must complete for us. These questions are the ones whose answers your attorney will be reviewing with you when you meet with him or her for your pre-hearing work-up.

The questionnaire you will complete for us was developed by the attorneys at Mike Murburg, P.A. to be extremely comprehensive and has taken over 20 years to develop. It literally contains every question and area of inquiry your Social Security judge can or will normally ask. It is absolutely necessary that you complete and answer all questions and return it to our office prior to your second meeting with your attorney at your pre-trial work-up. Your attorney will talk to you about the hearing process, procedures, protocol, and judge that will hear your case.

Please note that if you have moved or your hearing is outside the Tampa Bay - West Coast of Florida area, your meeting will be telephone or done via Skype or computer-telecamera over the internet. At your second meeting, your attorney will review your answers with you, make his own notes, and highlight the important facts and issues in your case. The third time you see your attorney will be the Social Security Administration office where your case will be tried. We usually arrive about an hour early for your hearing. The attorney will review the judge's file to make sure all exhibits

are in your Social Security Administration file and have copies made to supplement your file if necessary. Then your attorney will meet with you to review any last minute facts and issues and answer any of your remaining questions prior to the hearing. The judge will ask your attorney if she/he has personally reviewed your file that morning and to let the court know of any objections. The judge will confirm that your attorney has received the file and all pertinent issues with you, so we are very careful that this is all done.

The hearing is generally informal (only you, the judge, assistant and a medical or vocational evaluator will be in the hearing room), and you will be seated before the judge with your attorney. Your attorney, the judge, or both will direct questions to you and any subsequent medical or vocational witnesses who may testify after you.

When your hearing is over, the Court will "close the record," and your attorney will let you and the Court know that the attorney and you are getting up to leave by asking, "May we be excused now?" When the Court acknowledges this, you both may get up and leave the hearing room.

Just like a surgeon after surgery, your attorney will discuss any questions you may have subsequent to the hearing and await your favorable decision. If the decision is fully favorable, as is in the vast majority of the cases we accept, you will not need to meet with your attorney again. If your decision is partially favorable or unfavorable, a fourth meeting with him or her will be scheduled to discuss the trial record and appeal to the next level and into Federal District Court. If your case is reversed and remanded, you will see your attorney once again for another pre-trial work-up and at your rehearing should your case be remanded for trial by the Federal District Court Magistrate or judge who reversed the Social Security Administration judge's unfavorable decision.

Ultimately, if you obtain a favorable disability ruling, you will not need or want to see your attorney, unless you just want to stop by and say thank you.

### 134. If I appeal my claim to the federal court what happens to attorneys' fees?

The court can allow a reasonable fee for your attorney. The fee usually will not exceed 25% of all past-due benefits that result from the court's decision. Your attorney cannot charge any additional fee for services before the court. Your attorney may elect to be paid with your consent under the Equal Access to justice Act, but this will require a separate contract.

### 135. If I also have a Long Term Disability Carrier involved, are there any special considerations?

Yes. Submit the following documents to your Long Term Disability case manager:
1. Social Security Reimbursement Agreement

2. Authorization to Release Social Security Claim Related Information
3. Family Information Questionnaire
4. Your receipt of application from Social Security

Then, call your Long Term Disability case manager if you have any questions or concerns about applying for SSDI benefits.

# SOCIAL SECURITY RETIREMENT

**136. What are my retirement options?**

Retiring at full retirement age - to retire, you must have earned 40 credits. See the table below to determine your full retirement age.

Year of Birth
1937 or earlier
1938
1939
1940
1941
1942
1943-1954
1955
1956
1957
1958
1959
1960 or later

* Refer to the previous year if you were born January 1st.

Retiring early - If you've earned 40 credits, you can start receiving Social Security benefits at 62 or at any month between 62 and full retirement age. However, your benefits will be permanently reduced based on the number of months you receive benefits before you reach full retirement age.

If your full retirement age is 66, they will be reduced:

25% at age 62;
20% at age 63;
13 ½ % at age 64; or
6 2/3 % at age 65.

Receiving retirement benefits while you work - you can work while receiving monthly benefits. And it could mean a higher benefit that can be more important to you later in your life and increase future benefits your family and survivors could receive.

The SSA will review your record each year to see whether the additional earnings will increase your monthly benefit. If there's an increase, the SSA will send you a notice of

your new benefit amount. Earnings in or after the month you reach full retirement age won't reduce your Social Security benefits. However, if you receive benefits before reaching your full retirement age, your benefit amount will be reduced, unless you have been determined disabled by the SSA.
* In the year you reach full retirement age, $1 in benefits will be deducted for each $3 you earn above the annual limit (for example, $36,120 in 2008) until the month you reach full retirement age. After that, your benefits will not be reduced, no matter how much you earn.
* In the years before you reach full retirement age, $1 will be deducted for every $2 you earn above the limit ($13,560 in 2008).
If you lose benefits because of work, your benefit will be increased later to account for the months you didn't receive benefits before reaching full retirement age.

Delaying Retirement - you may decide to continue working beyond your full retirement age without choosing to receive benefits. If so, your benefit will be increased by a certain percentage for each month you don't receive benefits between your full retirement age and age 70. This table shows the rate your benefits will increase if you delay retiring:

Year of Birth
1937-1938
1939-1940
1941-1942
1943 or later

Applying for Social Security Retirement Benefits and Medicare - It's best to contact Social Security three months before the month in which you want to receive benefits to discuss the options that are available to you. In some cases, your choice of retirement month could mean additional benefits for you and your family.

Even if you don't plan to receive benefits because you'll continue working, or if you have filed for disability, you should sign up for Medicare three months before reaching age 65 regardless of when you reach full retirement age. Otherwise, your Medicare medical insurance (Part B) could be delayed and you could be charged a higher premium.

### 137. How do I apply for retirement benefits?

You can apply online at www.socialsecurity.gov/applyforbenefits or by calling 1-800-772-1213 between 7a.m. and 7p.m., Monday through Friday. If you are deaf or hard of hearing, call our TTY number 1-800-325-0778, between 7a.m. and 7p.m., Monday through Friday, to file your claim. You also can apply at any Social Security office. To avoid having to wait, you may want to call first to make an appointment.

Be sure to have these items handy: your Social Security number, birth certificate, W-2 forms or self-employment tax return for last year, and your bank name and account number so your benefits can be deposited directly into your account.

In addition to the information listed above, you will need:
* Your military discharge papers if you had military service;
* Your spouse's birth certificate and Social Security number and your marriage certificate if he or she is applying for benefits; and
* Proof of U.S. citizenship or lawful immigration status if you were not born in the United States.

You will need to mail or deliver original documents or copies that have been certified by the issuing office to the Social Security office.

### 138. What if I need more information on retirement benefits?

You also have options for getting information about Social Security and retirement. Visit the "Plan your Retirement" section of the SSA's website to estimate your Social Security benefits, find answers to frequently asked questions about Social Security, learn about factors that could affect your benefits, and much more. You can get information about Social Security by visiting a local Social Security office or by calling 1-800-772-1213

You can print these publications from the SSA website:
*Retirement Benefits (publication No. 05-10035)
*Your Retirement Benefits: How It Is Figured (publication No. 05-10070)

# SOCIAL SECURITY DISABILITY TAX QUESTIONS

This page gives general income tax guidance with citations and should not be used as the basis for tax advice in individual cases. Taxpayers should always seek guidance from competent tax professionals and should use this page only as an aid to asking the right questions.

**139. If I receive benefits, will I have to pay income taxes for the disability benefits I receive?**

Perhaps. Social Security disability benefits and retirement benefits are treated the same for income tax purposes. SSI benefits are not normally subject to income tax. Your taxes will also depend on your other income, credit deductions, and filing status.

**140. How should I handle income taxes on my retroactive lump sum payment of disability benefits?**

Social Security is required to send each benefit recipient an SSA-1099 by February 1 of the following year, specifying how much of the Social Security benefit received in the lump sum was really a payment for some prior year or years. The 1099 also lists the attorney fee. These SSA-1099 forms are often inaccurate, and the taxpayer must use award notices to double check the 1099.

**141. How much of my ongoing Social Security disability benefit is subject to income tax?**

The Basic Rule: Up to 50% of Social Security benefits are taxable if total "provisional income" (adjusted gross income, tax-exempt interest and one half of Social Security benefits) exceeds a base amount: $25,000 for single taxpayers and $32,000 for married taxpayers filing jointly. At this level, taxes are payable on the lesser of (1) 50% of Social Security benefits received, or (2) one half of the difference between provisional income and the applicable base amount. Fortunately, this is the end of the income taxation picture for most recipients of disability benefits.

The Second Tier: A second tier of income tax - reaching up to 85% of Social Security benefits received - kicks in (1) for single taxpayers with provisional income over $34,000, (2) for married taxpayers filing jointly with provisional income over $44,000, and (3) for all married taxpayers who file separate returns, but do not live apart.
For these second-tier categories, income taxes are payable on the lesser of (A) 85% of Social Security benefits or (B) the total of (1) 85% of the difference between provisional income and the applicable adjusted base amount ($34,000/$44,000), plus (2) the lesser of (a) half the benefits or (b) $4,500 (for singles / $6,000 (for married couples filing jointly). The adjusted base amount for married persons filing separately but living together is zero; taxes are payable on the lesser of 85% of benefits or 85% of provisional income.

**142. What about my attorney fee for the disability appeal - is it deductible?**

Attorney Fee Deduction: If a taxpayer discovers that some of the Social Security lump sum - when added to regular benefits received in the same year - turns out to be taxable, the attorney fee may be deducted from income, but only to the same extent that Social Security is taxed. For example, if a taxpayer paid tax on 50% of SSA benefits received, the taxpayer may deduct half of the attorney fee paid or incurred during the same year. [IRS Revenue Ruling 87-102] The taxpayer faces the burden of filing an itemized return, of course, and this limited deduction is further subject to the "2% of adjusted gross" ceiling on miscellaneous itemized deductions.

**143. I owe most of the Social Security lump sum to a long-term disability carrier, so how do I avoid double taxation**?

You can do this by lowering the tax impact of a lump sum. Congress has provided a special election allowing a client to take advantage of the tax exempt base amount for each of the retroactive years represented in a Social Security lump sum. [I.R. Code §86(e); see I.R.S. Publication 915] In most cases, this special election will be desirable, because it enables the taxpayer to offset the lump sum with a multiple of base amounts, described below. Also, the election removes the need to amend prior tax returns.

**144. Can my Social Security benefits tax be reduced by receiving other benefits?**

Yes. Your Social Security disability may be reduced for worker's compensation and other public disability benefits. Oddly, the amounts deducted are included as benefits received for purposes of income tax. In effect, state worker's compensation is rendered taxable in an amount equal to the Social Security reduction, but only to the extent that Social Security is taxable for the year. [I.R. Code §86(d)(3)]

**145. Will auxiliary child or spouse benefits be taxed?**

Yes. Auxiliary [child or spouse] benefits are included in the taxable income of the person who has the legal right to receive them. For example, a child's benefits are added to the child's other income (if any) to determine taxability, even though the benefits are paid on the parent's earnings record. The child receives a separate SSA-1099.

### 146. Should I engage in Voluntary Tax Withholding to legally avoid tax payments?

Perhaps. Voluntary Tax Withholding (VTW) from Social Security benefit income will help some taxpayers avoid quarterly estimated tax payments or an onerous lump sum due by April 15th. To begin or modify a withholding request, submit completed IRS Form W-4V to a local Social Security office. The available withholding rates are 7, 10, 15 or 27 percent. The form is posted on the Social Security web site: www.ssa.gov/taxwithhold.html.

### 147. What should I do if I used all or part of a Social Security back payment to reimburse a long-term disability carrier?

Special tax relief is available under §1341 of the Internal Revenue Code, again avoiding the need to amend a prior tax return. See IRS Publication 525. If the repayment to the LTD carrier is under $3,000, the taxpayer gets a deduction on the current year's tax return. For repayments over $3,000, the taxpayer chooses either the deduction or a tax credit for the excess tax paid in the prior year. A subtle tax issue to watch: LTD reimbursements to the carrier also cause "phantom" taxable income in some cases, due to the separate 1099 forms issued for the year by SSA and by the carrier.

### 148. If I become self-employed part-time, can you give me some helpful tips?

Since the self-employed pay all of their Social Security and Medicare taxes, these workers receive a Social Security tax deduction and an income tax deduction at tax time, designed to achieve parity with the employed, who do not pay FICA or income tax on the value of the employer's FICA tax payment. For the Social Security tax deduction, the self-employed deduct 7.65% of net earnings before computing the tax at 15.3%. For the income tax deduction, 50% of the net social security tax liability (after applying the Social Security tax deduction above) is deducted from gross earnings as a business expense.

# SOCIAL SECURITY DISABILITY FOR "CHILDREN"
## Minor (Under Age 18) Children's And Adult Child (Age 18-22) Claims

**1. Is there a special process for determining a child's disability that is different from an adult's?**

Yes. Since disabled children (0-18) and adult children (18-22) are not expected to have worked full time or long enough to have earned quartees to qualify for SSDI, special rules apply to them. Technically children are entitled not to SSDI benefits but to SSI benefits. The requirements for proving childhood disability and adult child disability are also different.

**2. Can a minor be considered disabled?**

Yes. Under section 1614(a)(3)(C) of the Social Security Act, an individual under the age of 18 shall be considered disabled if she has a medically determinable physical or mental impairment, which results in marked and severe functional limitations and can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the above, no individual under the age of 18 who engages in substantial gainful activity may be considered to be disabled.

**3. Are a disabled child's SSI benefits payable prior to the date his or her application is filed?**

No. Supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335).

**4. Under what authority can an ALJ find a child disabled?**

Under the authority of the Social Security Act, the Social Security Administration has established a three-step sequential evaluation process to determine whether an individual under the age of 18 is disabled (20 CFR 416.924(a)).

**5. What are the steps of analyses involved in determining whether a child is disabled?**

At step one, the ALJ must determine whether the claimant is engaging in substantial gainful activity. Substantial gainful activity is defined as work activity that is both substantial and gainful. An individual is engaging in substantial gainful activity if he/she is doing significant physical or mental activities for pay or profit (20 CFR 416.972). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in substantial gainful activity (20 CFR 416.974 and 416.975). If the claimant is performing substantial gainful work, he/she is not disabled regardless of his/her medical condition(s) (20 CFR 416.924(b)). If the claimant is not engaging in substantial gainful activity, the analysis proceeds to the second step.

**6. What is step two in determining whether a child is disabled?**

At step two, the ALJ must determine whether the claimant has a medically determinable "severe" impairment or a combination of impairments that is "severe." For an individual who has not attained age 18, a medically determinable impairment or combination of impairments is not severe if it is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations. If the claimant does not have a medically determinable severe impairment(s), he/she is not disabled (20 CFR 416.924(c)). If the claimant has a severe impairment(s), the analysis proceeds to the third step.

**7. What does step three entail?**

At step three, the ALJ must determine whether the claimant has an impairment or combination of impairments that meets or medically equals the criteria of a listing or that functionally equals the listings.

**8. What must the ALJ consider?**

In making this determination, the ALJ must consider the combined effect of all medically determinable impairments, even those that are not severe (20 CFR 416.923, 416.924a(b)(4), and 416.926a(a) and (c)). If the claimant has an impairment or combination of impairments that meets, medically equals, or functionally equals the

listings, and it has lasted or is expected to last for a continuous period of at least 12 months, he/she is presumed to be disabled. If not, the claimant is not disabled (20 CFR 416.924(d)).

**9. What is the purpose of using the "Six Domains" and functionally equaling a listing?**

In determining whether an impairment or combination of impairments functionally equals the listings, the ALJ must assess the claimant's functioning in terms of 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.

**10. What does an ALJ have to do to make this disability assessment?**

In making this assessment, the ALJ must compare how appropriately, effectively and independently the claimant performs activities compared to the performance of other children of the same age who do not have impairments. To functionally equal the listings, the claimant's impairment or combination of impairments must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain (20 CFR 416.926a(d)).

**11. What else does an ALJ have to consider in determining if a child is disabled?**

In assessing whether the claimant has "marked" or "extreme" limitations, the ALJ must consider the functional limitations from all medically determinable impairments, including any impairments that are not severe (20 CFR 416.926a(a)). The ALJ must consider the interactive and cumulative effects of the claimant's impairment or multiple impairments in any affected domain (20 CFR 416.926a(c)).

**12. What does Social Security mean by a child's "marked" limitation?**

Social Security regulation 20 CFR 416.926a(e)(2) explains that a child has a "marked limitation" in a domain when his/her impairment(s) "interferes seriously" with the ability to independently initiate, sustain, or complete activities. A child's day-to-day functioning may be seriously limited when the impairment(s) limits only one activity, or when the interactive and cumulative effects of the impairment(s) limit several activities. The regulations also explain that a "marked" limitation also means:

1. A limitation that is "more than moderate" but "less than extreme."

2. The equivalent of functioning that would be expected on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.

3. A valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and his/her day-to-day functioning in domain-related activities is consistent with that score.

4. For the domain of health and physical well-being, frequent episodes of illnesses because of the impairment(s) or frequent exacerbations of the impairment(s) that results in significant, documented symptoms or signs that occur: (a) on an average of 3 times a year or once every 4 months, each lasting 2 weeks or more; (b) more often than 3 times a year or once every 4 months but not lasting for 2 weeks; or (c) less often than an average of 3 times a year or once every 4 months but lasting longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

**13. What is an "extreme" limitation according to Social Security?**

Social Security regulation 20 CFR 416.926a(e)(3) explains that a child has an "extreme" limitation in a domain when her impairment(s) interferes "very seriously" with her ability to independently initiate, sustain, or complete activities. A child's day-to-day functioning may be very seriously limited when his/her impairment(s) limits only one activity or when the interactive and cumulative effects of his/her impairment(s) limit several activities. The regulations also explain that an "extreme" limitation also means:

1. A limitation that is "more than marked."

2. The equivalent of functioning that would be expected on standardized testing with scores that are at least three standard deviations below the mean.

3. A valid score is three standard deviations or more below the mean on a comprehensive standardized test that is designed to measure ability or functioning in that domain and his/her day-to-day functioning in domain-related activities that is consistent with that score.

4. For the domain of health and physical well-being, episodes of illness or exacerbations that result in significant, documented symptoms or signs substantially in excess of the requirements for showing a "marked" limitation.

**14. What must an ALJ do to determine the degree of limitations in each of the "Six Functional Domains"?**

In determining the degree of limitation in each of the six functional domains, the ALJ has to consider all symptoms and the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929, SSRs 96-4p and 96-7p. The ALJ has to also consider the opinion evidence in accordance with 20 CFR 416.927 and SSRs 96-2p, 96-5, 96-6p and 06-3p.

### 15. How does an ALJ evaluate a child claimant's symptoms?

In considering a claimant's symptoms, the ALJ must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)—i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques—that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the ALJ must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the ALJ must make a finding on the credibility of the statements based on a consideration of the entire case record.

For example, after considering the evidence of record, the ALJ finds that a claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms; however, the statements concerning the intensity, persistence, and limiting effects of the claimant's symptoms are no credible to the extent that the statements are inconsistent with finding that the claimant does not have an impairment or combination of impairments that functionally equals a listing.

For example, if a child were able to attend school in a regular classroom setting and is described as an average student and was participating in physical education and the evidence does not document any restrictions placed on the claimant's ability to function by any treating or examining physician of record, in terms of the six domains of function the ALJ would probably find the limitations caused by the claimant's impairments to be minimal.

### 16. What is the first of the six "Functional Domains"?

The first domain is "acquiring and using information." This domain considers how well a child is able to acquire or learn information and use the information he/she has learned (20 CFR 416.926a(g)).

The regulations provide that a preschooler (i.e., a child age 3 to attainment of age 6) without an impairment should begin to learn and use the skills that will help her to read and write and do arithmetic when she is older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what he/she means, and tell stories allows the child to acquire and share knowledge and experience of the world around him/her. All of these are called "readiness skills" and the child should have them by the time she beings first grade (20 CFR 416.926a(g)(2)(iii)).

The regulations provide that a school-age child (i.e., a child age 6 to the attainment of age 12) without an impairment should be able to learn to read, write, do math, and discuss history and science. The child will need to use these skills in academic situations to demonstrate what he/she has learned by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. The child will also need to use these skills in daily living situations at home and in the community (e.g., reading street signs, telling times, and making change). The child should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing his/her own ideas, and by understanding and responding to the opinions of others (20 CFR 416.926a(g)(2)(iv)).

Social Security regulation 20 CFR 416.926a(g)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in acquiring and using information are: (i) does not understand words about space, size, or time (e.g., in/under, big/little, morning/night); (ii) cannot rhyme words or the sounds in words; (iii) has difficulty recalling important things learned in school yesterday; (iv) has difficulty solving mathematics questions or computing arithmetic answers; or (v) talks only in short, simple sentences, and has difficulty explaining what she means.

If the claimant has no limitation in acquiring and using information, the claimant would normally be in a regular classroom setting with no difficulty shown.

### 17. What is the second of the six "Functional Domains"?

The second domain is "attending and completing tasks." This domain considers how well a child is able to focus and maintain attention, and how well he/she is able to begin, carry through, and finish activities, including the pace at which he/she performs activities and the ease of changing activities (20 CFR 416.926a(h)).

The regulations provide that a preschooler without an impairment should be able to pay attention when he/she is spoken to directly, sustain attention to his/her play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. The child should also be able to focus long enough to do many more things independently, such as gathering clothes and dressing, feeding, or putting away toys. The child should usually be able to wait his/her turn and to change his/her activity when a caregiver or teacher says it is time to do something else (20 CFR 416.926a(h)(2)(iii)).

The regulations provide that a school-age child without an impairment should be able to focus her attention in a variety of situations in order to follow directions, remember and organize school materials, and complete classroom and homework assignments. The child should be able to concentrate on details and not make careless mistakes in his/her work (beyond what would be expected in other children of the same age who do not have impairments). The child should be able to change activities or routines without distraction, and stay on task and in place when appropriate. The child should be able to sustain attention well enough to participate in group sports, read by himself/herself, and complete family chores. The child should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation (20 CFR 416.926a(h)(2)(iv)).

Social Security regulation 20 CFR 416.926a(h)(3) sets forth some examples of limited functioning in this domain in which children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in attending and completing tasks are: (i) is easily startled, distracted, or over-reactive to sounds, sights, movements, or touch; (ii) is slow to focus on, or fails to complete, activities of interest (e.g., games or art projects); (iii) repeatedly becomes side-tracked from activities or frequently interrupts others; (iv) is easily frustrated and gives up on tasks, including ones he/she is capable of completing; or (v) requires extra supervision to remain engaged in an activity.

If the claimant has no limitation in attending and completing tasks, the evidence of record would not show any evidence of deficit.

**18. What is the third of the six "Functional Domains"?**

The third domain is "interacting and relating with others." This domain considers how well a child is able to initiate and sustain emotional connections with others, develop, and use the language of the community, cooperate with others, comply with rules, respond to criticism, and respect and take care of the possessions of others (20 CFR 416.926a(i)).

The regulations provide that a preschooler without an impairment should be able to socialize with children as well as adults. The child should begin to prefer playmates and start developing friendships with children who are his/her own age. The child should be able to use words instead of actions to express himself/herself, and also be better able to share, show affection, and offer to help. The child should be able to relate to caregivers with increasing independence, choose his/her own friends, and play cooperatively with other children, one-at-a-time or in a group, without continual adult supervision. The child should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speaking clearly enough that both familiar and unfamiliar listeners can understand what he/she says most of the time (20CFR 416.926a(i)(2)(iii)).

The regulations provide that a school-age child without an impairment should be developing more lasting friendships with children who are of the same age. The child should begin to understand how to work in groups to create projects and solve problems. The child should have an increasing ability to understand another's point of view and to tolerate differences. The child should be well able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners can readily understand (20 CFR 416.926a(i)(2)(iv)).

Social Security regulation 20 CFR 416.926a(i)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty that children could have in interacting and relating with others are: (i) does not reach out to picked up and held by a caregiver; (ii) has no close friends or all friends are older or younger than the child; (iii) avoids or withdraws from people he/she knows, or is overly anxious or fearful of meeting new people; (iv) has difficulty playing games or sports with rules; (v) has difficulty communicating with others (e.g., in using verbal and nonverbal skills to express herself, in carrying on a conversation, or in asking others for assistance); or (vi) has difficulty speaking intelligibly or with adequate fluency.

A claimant would have no limitation in interacting and relating with others if the evidence does not show any allegation of or objective evidence of any speech or communication disorder.

### 19. What is the fourth of the six "Functional domains"?

The fourth domain is "moving about and manipulating objects." This domain considers how well a child is able to move his/her body from one place to another and how a child moves and manipulates objects. These are called gross and fine motor skills (20 CFR 416.926a(j)).

The regulations provide that a preschooler without an impairment should be able to walk and run with ease. The child's gross motor skills should let his/her climb stairs and playground equipment with little supervision and let him/her play more independently (e.g., swing by herself and possibly start learning to ride a tricycle). The child's fine motor skills should also be developing. The child should be able to complete puzzles easily, string beads, and build with an assortment of blocks. The child should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners (20 CFR 416.926a(j)(2)(iii)).

The regulations provide that a school-age child without an impairment should have gross motor skills that let him/her move at an efficient pace at school, home, and throughout the neighborhood. The child's increasing strength and coordination should expand her/him ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching, and hitting balls in informal play or organized sports. The child's development of fine motor skills should enable him/her to do things like use many kitchen and household tools independently, use scissors, and write (20 CFR 416.926a(j)(2)(iv)).

Social Security regulation 20 CFR 416.926a(j)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in moving about and manipulating objects are: (i) difficulty with motor activities (e.g., stumbling, unintentionally dropping things) because of muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia); (ii) difficulty with balance or climbing up and down stairs or jerky or disorganized locomotion; (iii) difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, running, jumping rope, or riding a bike); (iv) difficulty with sequencing hand or finger movements; (v) difficulty with fine motor movement (e.g., gripping or grasping objects); or (vi) poor eye-hand coordination when using a pencil or scissors.

A claimant has no limitation in moving about and manipulating objects if the examination of the claimant had not shown any neurological or orthopedic deficits, or that a claimant participates in physical education at school and physical education was one of his/her favorite classes.

### 20. What is the fifth of the six "functional domains"?

The fifth domain is "caring for yourself." This domain considers how well a child maintains a healthy emotional and physical state, including how well a child satisfies her physical and emotional wants and needs in appropriate ways. This includes how the

child copes with stress and changes in the environment and whether the child takes care of his/her own health, possessions, and living area (20 CFR 416.926a(k)).

The regulations provide that a preschooler without an impairment should want to take care of many of his/her own physical needs (e.g., putting on shoes, getting a snack), and also want to try doing some things that he/she cannot do fully (e.g., tying shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for the child to agree to do what his/her caregiver asks. Later, that may be difficult for the child because he/she wants to do things her way or not at all. These changes usually mean that the child is more confident about his/her ideas and what he/she is able to do. The child should also begin to understand how to control behaviors that are not good for himself/herself (e.g., crossing the street without an adult) (20 CFR 416.926a(k)(2)(iii)).

The regulations provide that a school-age child without an impairment should be independent in most day-to-day activities (e.g., dressing and bathing), although he/she may still need to be reminded sometimes to do these routinely. The child should begin to recognize that she is competent in doing some activities but has difficulty doing others. The child should be able to identify those circumstances when he/she feels good about himself/herself and when he/she feels bad. The child should begin to develop understand of what is right and wrong and what is acceptable and unacceptable behavior. The child should also begin to demonstrate consistent control over her behavior and be able to avoid behaviors that are unsafe or otherwise not good for him/her. At this age, the child should begin imitating more of the behavior of adults he/she knows (20 CFR 416.926a(k)(2)(iv)).

Social Security regulation 20 CFR 416.926a(k)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in caring for themselves are: 9i) continues to place non-nutritive or inedible objects in the mouth; (ii) often uses self-soothing activities that are developmentally regressive (e.g., thumb-sucking or re-chewing food); (iii) does not dress or bathe age-appropriately; (iv) engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take medication), or ignores safety rules; (v) does not spontaneously pursue enjoyable activities or interests; or (vi) has disturbances in eating or sleeping patterns.

A claimant would have no limitation in the ability to care for herself if no problems were alleged in this area and no deficits were observed by any treating sources.

**21. What is the last of the six "functional domains"?**

The sixth domain is "health and physical well-being." This domain considers the cumulative physical effects of physical and mental impairments and any associated treatments or therapies on a child's functioning that were not considered in the evaluation of the child's ability to move about and manipulate objects (20 CFR 416.929a(l)).

Social Security regulation 20 CFR416.926a(l)(3) sets forth some examples of limited functioning in this domain that children of any age might have; however the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have involving their health and physical well-being are: (i) generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of any impairment(s); (ii) somatic complaints related to an impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches or insomnia); (iii) limitations in physical functioning because of treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments); (iv) exacerbations from an impairment(s) that interfere with physical functioning; or (v) medical fragility requiring intensive medical care to maintain level of health and physical well-being.

If a claimant has no marked limitation in health and physical well-being, she does not fulfill the domain criteria.

**22. If a child has only one "marked" limitation and no "severe" ones, can she be found to be disabled?**

No. Accordingly, if a claimant does not have any impairment or combination of impairments that result in either "marked" limitations in two domains of functioning or "extreme" limitation in one domain of functioning.

**23. How is entitlement for Disabled Adult Child's benefits made?**

You must be age 18 or older, and your health problems must:

* begin before age 22 or you must become disabled again within 7 years after the month that your earlier period of disability ended,
* keep you from doing any kind of substantial work (described below), and
* last or be expected to last for at least 12 months in a row, or result in death.

How does marriage and divorce affect my Adult-Child Disability benefits?

Although marriage terminates disabled adult child's benefits, initial entitlement requires only that the claimant be unmarried. 42 U.S.C. §402(d)(1)(B), 20 C.F.R §404.350(a)(4). So, before applying for benefits, a claimant may be both married and divorced. It is also

possible, where benefits of a disabled adult child are terminated because of marriage and that marriage ends, that the disabled adult child, now unmarried, can apply for benefits on the other parents account. A claimant who is married when the application is filed may be entitled to benefits in the period prior to the month of marriage. POMS DI 10115.001.

### 24. How are Adult Child benefits terminated?

Benefits of a disabled adult child end for all the same reasons an adult beneficiary's benefits end, e.g., end of disability, death. In addition to terminating when a disabled adult child marries, benefits for a disabled adult child end if the insured person's disability or retirement benefits end for a reason other than death. An exception is: if the insured benefits are lost due to drug addiction or alcoholism that was found to be material to the insured's disability. For so long as the insured remains disabled, the disabled adult child is entitled to benefits. 20 C.F.R. §404.352(b)(5).

### 25. How does one prove Re-Entitlement to Childhood Disability benefits?

If childhood disability benefits end due to the cessation of the child's disability, that child may be re-entitled to benefits once based on the same earnings record if the child again becomes disabled prior to 84 months (7 years) passing after the last period of benefits ended. We note though that contrary to this general rule, Congress established an exception to the seven-year time limit and removed it for those whose benefits ceased because their return to work and the performance of substantial gainful activity, effective October 1, 2004. Section 420A of Public Law 108-203, the Social Security Protection Act of 2003. So, to be re-entitled, a child must not have married unless that marriage is void or was annulled. 20 C.F.R. §404.351. A marriage that ends because of divorce or death keeps the child from further entitlement. The requirements for initial entitlement, requires only that the child not be married when he or she applies. Marriage and divorce terminate receipt not initial entitlement.

Re-entitlement rules do not apply when the child's benefits end because of the parent's disability ended. If the parent becomes entitled to disability benefits again or retires or dies, the initial entitlement provisions apply. POMS DI 10115.035

There is also an exception to the exception discussed above in that initial entitlement rules will apply if the child applies for benefits on the other parent's account, where a child marries and loses benefits on one parent account after divorce and based on the other parent's account.

# MEDICARE AND MEDICAID

**1. When does the patient's eligibility for Medicaid or Medicare benefits start**?

Eligibility for Medicaid begins on the date the SSA determined the claimant was disabled. So for the two years immediately subsequent to the claimant's first day of being disabled the claimant's medical bills will be paid by Medicaid. (Example, John Doe applies for disability (SSDI and SSI) on 1/5/06 saying he was disabled 12 months prior on 1/5/05. On 1/5/07 the SSA determines John Doe was disable as of 1/5/05 as he alleged. John's Medical bill between 1/5/05 and 1/507 are billable reimbursable under Medicaid. After 1/5/07 John Doe's bills are payable through Medicare.)

On the second anniversary of the Claimant's first date of disability as determined by the SSA (or upon reaching full retirement age whichever is first) the claimant becomes eligible for Medicare.

For further information on Medicaid, Medicare and supplemental insurance issues we invite you to visit www.insureflorida.info.

**2. How long must I wait for my Medicare Card?**

You cannot get your Medicare card until after you have been disabled for two years and five months. If you have already been disabled for two years and five months, you should keep track of your medical bills so that these may be submitted later to Social Security if we win.

**3. How long must I wait for Medicaid?**

There is no waiting period for Medicaid, but you have to be very poor to qualify for it. You also have to apply specifically for it, unlike Medicare. If you have filed a claim for Supplemental Security Income (SSI) you can probably qualify for Medicaid if you win. You will not likely qualify for Medicaid unless, and until, you win. If you have filed a claim for Medicaid in the past, keep all of your medical bills in your legal file so that you may later take them to the Department of Social Services to get them paid if you win your Social Security case. If you have applied for Social Security Income (SSI), you should now apply for Medicaid. You can only get Medicaid for three months prior to your first claim for Medicaid.

**4. Where do I apply for Medicaid?**

You apply for Medicaid at the County Department of Social Services (not Social Security). They will turn you down, but if we win your Social Security case they will later change this decision and award you back Medicaid benefits.

If you get your health care through Medicaid, you are also enrolled in the Medipass program. YOU NEED TO KNOW THIS!

**5. Ifs a new law is changing how Medipass works?**

Each year, you get notice from Medicaid of an "open enrollment period." After October 1, when you get your open enrollment notice, you will need to contact Medicaid if you want to stay in Medipass. If you don't contact them, Medicaid will automatically switch you out of Medipass and into a health plan (HMO).

**6. What will happen if I am switched to an HMO?**

Medipass is a program run by the state. HMOs are run by insurance companies. If you are switched from Medipass to an HMO, you may not be able to see your doctors, and coverage for some of you medications may be denied or delayed. HMOs can also limit the services you get, even if your doctor wants you to get them.

**7. What should I do about enrollment?**

Watch you mail for a notice from Medicaid telling you about your open enrollment period and this change. If you want to stay in Medipass, you must contact Medicaid Options (the State's Medicaid enrollment broker) at 1-888-367-6554. Be sure to act right away once you receive your open enrollment notice. Your open enrollment period is only 30 days long.

NOTE: We don't know yet how Medicaid will notify you of this change, but as information becomes available, it will be posted online at: www.floridachain.org/medipass.htm

**8. Can I get back into Medipass if I get switched to an HMO?**

Maybe, but Medicaid has not said how it will handle this yet either. If you find out that you were switched to an HMO but wanted to stay in Medipass, call Medicaid Options right away. Ask if you can be switched back to Medipass.

**9. Whom can I contact to ask questions?**

Call Medicaid Options at 1-88-367-6554 on Mon-Fri from 8 AM - 7PM. (TDD users only, call 1-800-653-9803.)

# FLORIDA SECTION

This section is written specifically for residents of the state of Florida. Laws differ from state to state, so if you have questions about these laws or similar issues, please consult an experienced Social Security Disability attorney of Personal Injury in your state.

**10. Does this change apply to Medicaid consumers in the following Florida counties?**

YES: Brevard, Gadsden, Hernando, Highlands, Hillsborough, Jefferson, Lake, Lee, Leon, Madison, Manatee, Miami-Dade, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Volusia, & Wakulla.

**11. In Florida, if I am disabled and a Medicare recipient, can a physician legally charge me more than Medicare will allow?**

No. Florida Statute §456.056, Treatment of Medicare Beneficiaries, provides in pertinent part of the following:

(5) Any attempt by a primary physician or a consulting physician to collect from a Medicare Beneficiary any amount of charges for medical services in excess of those authorized under this Section, other than the unmet deductible and the 20 percent of charges that Medicare does not pay, shall be deemed null, void, and of no merit.

**12. So, if I am in an accident, what should I do?**

You may have only a limited amount of PIP benefits, so in writing, advise your physician that after your PIP benefits are exhausted, they should bill Medicare for their services after your PIP benefits run out, otherwise you may be forced into litigation over your bill.

**13. Does Florida law define me as a Medicare recipient?**

Florida Statute Section 456.056 defines "Beneficiary" as a "beneficiary of health insurance under Title XVIII of the federal Social Security Act." (42 U.S.C. § 1395 et seq., Health Insurance for Aged and Disabled).

If I become a Plaintiff and am already a Medicare Beneficiary and sustain injury, who is liable for damages including the amounts that treating physicians charged under contract/letters of protection?

You are liable to your physicians for bills you incur even though the person who caused you injury may be liable to you to compensate you for those damages. If you assign your claim in writing to your physician, that physician has your claim for the bills you incurred to him on account of someone else's negligence, but this recovery is a limited one.

1. Pursuant to Florida Statute §465.056 treating physicians are limited to charges authorized by Medicare as found in 42 U.S.C § 1395 et seq., which provides that physicians may charge only a limited amount above the Medicare-Approved Amount when the physician does not accept assignment of the claim. See 42 U.S.C. § 1395w-4 et seq., 42 C.F.R. §§ 424.56 and 414.48.

2. Medicare set the limiting charges for years subsequent to 1993 at 115% of the Medicare-Approved amount for unassigned claims. See 42 C.F.R §414.20 and 42 C.F.R. §414.48 (if the physician accepts assignment of the claim, the physician is limited to only 100 percent of the Medicare-Approved Amount.)

3. Moreover pursuant to 42 U.S.C.A § 1395w-4 (g), no Medicare Beneficiary is liable for payments of any amounts billed for service in excess of the limiting charge.

4. Physicians who are enrolled with Medicare are bound by agreements not to charge Medicare Beneficiaries individually for services that the individual could have had covered under Medicare. See 42 U.S.C. §1395cc. So, notify your physician immediately that you are a Medicare recipient so he/she is not stuck holding the bag for hisher services or expecting you to make payments that Medicare would otherwise make.

**14. How can a physician go about legally charging me more than Medicare will pay?**

If a physician seeks to have a Medicare Beneficiary held liable as an individual for charges that are in excess of the Medicare-Approved Amounts, the physician must meet the requirements of 42 U.S.C. §1395a that mandates a written contract between the physician and the Medicare Beneficiary must be entered into and signed by both individuals that the contract set forth the specific services to be provided, that the Medicare Beneficiary will not submit a claim to Medicare, that the Medicare Beneficiary understands he or she will be responsible for payment of services and that Medicare will not reimburse him or her for those services, that the Medicare Beneficiary acknowledges there exists limits under Medicare regulations limiting charges to specific amounts, that the Medicare Beneficiary has the right to services provided by other physicians who would limit their charges to Medicare-Approved Amounts, and that the physician indicate whether or not he or she is a participant in the Medicare program. If no contracts that meet these requirements exist, then your physician may not collect more then the Medicare allotted amounts.

In addition to the contractual requirements, the physician must notify Medicare by way of affidavit, stating that the physician will not submit a claim under Medicare for services provided to the Medicare Beneficiary for at least two years after executing the contract. If the physician fails to abide by the regulations and codes under 42 U.S.C. § 1395 et seq, the physician may be subject to sanctions, including fines amounting to two to three times the excessive charge, removal from the Medicare program, refunding of any payments made by the beneficiary that are excessive and assessment of $2,000.00 for each instance of excessive billing.

It is obvious that Medicare does not want Medicare Beneficiaries to be taken advantage of by physicians circumventing the Beneficiaries right to have the charges limited by Medicare.

**15. So, how would this work out in an accident case involving a Medicare Beneficiary?**

For example, in an accident case, it is not unusual for physicians to bill the injured patient in excess of Medicare paid services because there is a financial incentive to do so. If the American Orthopedic Institute billed $35,417.47 over the limiting charges allowed by

Medicare for the arthroscopic surgery for knee meniscus tear and related services. Dr. Smith billed $779.44 over the limiting charges allowed by Medicare for a single office visit and Calcium Chiropractic and Rehab billed $2481.28 over the limiting charges allowed by Medicare for chiropractic care and services. Billing amounts for these physicians exceed $46,018.35, which exceeds the Medicare-Approved amounts by at the least $40,000.00. The actual Medicare-Approved amounts equate to only about $7,440.00 for these services.

**16. How do courts limit these recoveries from physicians in Florida?**

The Second District Court of Appeal addressed the admissibility of charges exceeding Medicare amounts in Cooperative Leasing Inc. and Domer v. Johnson, 872 So.2d 956, (Flat 2d DCA 2004). The facts in Cooperative were that a motorist was injured in an automobile accident and the trial court allowed into evidence bills for all medical expenses. The bills were in excess of benefits paid by Medicare. The Second DCA ruled that the excessive billing was inadmissible because the plaintiff was not liable for the excessive billing pursuant to Title 42 U.S.C. §1395 and precedent. In citing the U.S.C., the Second District determined that the plaintiff's medical bills were paid by Medicare at the Medicare-approved amounts and that the physician could not recover from the plaintiff personally. The Second District goes on to provide precedent that the plaintiff is entitled to compensation for reasonably valued medical care and found that the Medicare amounts paid to the physicians were customary and reasonable. This is also the basis for approved amounts under 42 U.S.C. §1395w-4. Therefore, any amounts in excess of the Medicare-approved amounts would allow the plaintiff to receive a windfall by recovering "phantom damages," Id, at 959. In its ruling, the Second District goes on to provide that the difference between what the physicians charged and the Medicare-Approved Amounts are not a collateral source that would be deducted as a set-off post verdict. Id. at 960.

Moreover, all billing of the above physicians that do not meet the requirements for contracting with a Medicare Beneficiary and/or that are in excess of the Medicare-Approved Amounts are null, void, and of no merit as a matter of law pursuant to Florida Statute §456.056 It is of the utmost importance, therefore that if you are involved in any accident that you let your treating physician know you are disabled and on Medicare, so that you do not create any outstanding bills or bad-will by failing to tell your physician up front to bill Medicare, especially if you are involved in an accident other than one involving a car or other passenger vehicle.

**17. So, are there limits on Medicare's recovery of health insurance benefit payments made on my behalf if I have available Liability or Workers' Compensation insurance available and my case has not yet settled?**

Yes. When a Medicare beneficiary is injured Medicare will pay for accident related expenses normally covered by private insurance companies including automobile insurance and Workers' Compensation coverage, but only when payments from private insurance sources cannot be expected to be promptly made.

**18. How does Medicare affect tort liability cases?**

In liability cases, Medicare will look to the recipient to reimburse Medicare for payments Medicare has made for accident related expenses that were made prior to the settlement of the personal injury case. As of 12/01/11 there was no requirement that a litigant reimburse Medicare for future injury related medical expenses. If this were to occur, then, as it presently does in Workers' Compensation cases, Medicare could require "Set-Aside" Arrangements.

**19. How does Medicare affect Workers' Compensation cases?**

In Workers' Comp cases where there is no dispute over liability, and the case is to be settled in a lump sum of WC benefits, MSP (Medicare Second Payer) and CMS (Centers for Medicare and Medicaid Services) will require a "Medicare Set - Aside Arrangement requiring CMS approval of the Settlement or Set-Aside to assure that the injured beneficiary's future medical expenses will not be paid for by Medicare but from the proceeds actually and reasonably set aside by the recipient as a consequence of the settlement.

There is a different rule that applies to Lump Sum Settlements that are a compromise of a WC claim that the parties have negotiated which is less than the full amount of total compensation or where there is a bona fide dispute as to liability. See 42 C.F.R Section 411.46 generally and www.cms.hhs.gov/Manuals/IOM .

**20. What to do if I need even more information about Social Security Disability and other SSA programs?**

If you need more information - visit http://www.socialsecurity.gov/mystatement on the Internet, contact any Social Security office, call 1-800-772-1213, or write to Social Security Administration, Office of Earnings operation, P.O. Box 33026, Baltimore, MD 21290-3026. If you are deaf or hard of hearing, call TTY 1-800-325-0778. If you have questions about your personal information, you must provide your complete Social Security number. If your address is incorrect on this Statement, ask the Internal Revenue Service to send you a Form 8822. The Social Security Administration won't keep your address if you're not receiving Social Security Benefits.

# SOC. SEC. DISABILITY: PHYSICIANS' QUESTIONS

This section has been written so that physicians who are treating the disabled may be further educated as to the administrative an bureaucratic obstacles that face the disabled in their quest to obtain Social Security Disability Insurance and SSI benefits.

**1. How does it financially benefit a physician to assist the disabled?**

The disabled often lack medical care, because they have stopped working and, therefore, have no funds or medical insurance for medical treatment. The disabled, once adjudicated, can get health insurance through Medicaid and then Medicare insurance. The disabled prior to their adjudication by the Social Security Administration, often fall into the gap of having difficulty obtaining the evidence needed to prove to the Social Security Administration the severity and true nature of their affliction. If physicians would be

willing to treat a disabled person prior to his or her receiving disability benefits and honestly fill out one or two short forms to provide evidence of the disability, that doctor would help the disabled patient gather necessary evidence to get necessary medical treatment. In return, hopefully the physician obtain a life-long patient with a lifetime of Medicare Health Insurance once the patient is found to be disabled by the Social Security Administration.

**2. I thought Social Security had their own doctors who determine disability; is that correct?**

No. After 25 years of practice, it plainly seems to me that the Social Security Administration has physicians look at a claimant's initial claim and the earliest parts of the medical record for the purpose of stating that a claimant is capable of doing a full range of light duty or sedentary work and work without interruption by symptoms or need medical care forty hours per week. With reference to "Examining Physicians," the doctors contracted to the SSA are usually general practitioners or family practitioners who do cursory physical examinations of claimants to see if they can see, hear, walk heel to toe, get on and off an examining table. Sometimes they may ask a claimant to grip the physician's fingers or touch the claimant's toes. The evaluation is a one shot, five-minute deal and the physician is not one who knows the claimant or has a patient - physician relationship. The evaluations, at best, produce ambiguously written information that hardly, if ever results in an Administrative finding of disability. These physicians often are afraid to write favorable observations and seem to think they are at risk losing their Social Security referral source. Moreover, the reports the SSA physician writes normally do not take into consideration the evaluations and treatment notes of the claimant's treating physicians. They also do not specifically address that claimant's Residual Functional Capacity for sitting, standing, walking, pain, memory, and ability to concentrate. This is why the Administrative Law Judge pays little deference to reports filed by non-treating SSA doctors. It is noteworthy that the rules pertaining to Judicial evaluations of patient evidence require the Administrative Law Judge to pay "great deference" and give "significant weight" to the regards and opinions of "Treating Physicians and Sources" to the extent that those opinions are consistent with the patient's treatment records. This is why we specifically request our clients who have treating sources to fill-out "RFC" Residual Functional Capacity Questionnaires for our clients that can truthfully and factually relate what the claimant's limitations are.

Am I, the patient's treating physician, qualified to complete a Residual Functional Capacity form for my patient? Don't I need to send the patient out for a Functional Capacity Evaluation?

The Social Security Administration (SSA) recognizes that Functional Capacity Evaluations (FCES) are costly and can reflect the bias of the technician who is not a medical doctor. As a consequence, the SSA puts great faith in the ability of treating physicians to determine the reasonable limitations on the claimant's ability to sit, stand,

walk, reach, bend etc. based on the consistency of the patient's clinical presentation and objective medical evidence of record.

The SSA actually encourages the patient's treating physicians to complete Questionnaires that address Residual Physical and Mental Functional Capacity and will send such questionnaires out to treating physicians to complete. There is no special training, courses, or outside source requirements to complete these forms. ALL that is necessary is just an honest knowledge of the patient and desire to provide a reasonable medical opinion as to the patient's limitations. An Administrative Law Judge will consider the limitations along with all the other evidence in the claimant's file. In order to make an Administrative determination of disability that will be based on the Claimant's medical diagnosis, residual physical and/or mental capacities, and a determination that is based on all the above, the claimant is unable to perform work that exists in sufficient numbers in the National Economy. Thus, "Disability" is ultimately a Vocational issue that is applied to the medical evidence and opinions of record. If based on the claimant's age, education, transferrable job skills and ability to read and write the English language and residual functional capacity, no such jobs are available in the National economy in sufficient numbers to accommodate the claimant with his or her limitations, the claimant is considered disabled pursuant to Social Security Disability Guidelines. So one can see how helpful the conscientious completion of an RFC form by a treating physician truly is.

**3. When does the patient's eligibility for Medicaid or Medicare benefits start?**

Eligibility for Medicaid begins on the date the SSA determined the claimant was disabled. For the two years immediately subsequent to the claimant's first day of being disabled, the claimant's medical bills will be paid by Medicaid. (Example, John Doe applies for disability (SSDI and SSI) on 1/5/06 saying he was disabled 12 months prior on 1/5/05. On 1/5/07 the SSA determines John Doe was disable as of 1/5/05 as he alleged. John's Medical bill between 1/5/05 and 1/507 are billable reimbursable under Medicaid. After 1/5/07 John Doe's bills are payable through Medicare.)

On the second anniversary of the claimant's first date of disability as determined by the SSA (or upon reaching full retirement age whichever is first) the claimant becomes eligible for Medicare.

For further information on Medicaid, Medicare, and supplemental insurance issues we invite you to visit www.insureflorida.info.

**4. How can I learn more about Social Security disability and issues involving payment for patient services under Medicare and Medicaid?**

Our law firm has seven offices conveniently located throughout the Tampa Bay area. You can read more about us and find answers to common questions for treating doctors

on this site www.disabilityattorney.net. We can also offer a half hour presentation to educate your staff about the Social Security system, as well as what your patients need to prove eligibility for obtaining Medicare insurance as a disabled person. We also will be able to answer any of your Medicare/Disability questions thereafter. If you are interested in obtaining this information, please contact our office manager, Patricia Bretz at or office 888-NMM-LAWS or 813-264-5363.

We look forward to building a productive relationship with your office to help these disabled patients/clients obtain the medical and disability benefits they have earned and deserve. We look forward to hearing from you.

**5. If a patient is in dire need of a transplant or in danger of losing his or her life without medical care and treatment, how would such a case be handled if that person was not already on Medicare?**

There is such a thing known as a "Compassionate Allowance Cases." Such a case brings on an expedited high alert at the Social Security Administration. Even though an attorney would not earn any fees handling such a case, we do all the time as a service to our community. Please refer to the other FAQS Social Security Disability Sections on this website or go to: http://www.ssa.gov/compassionateallowances to learn more.

**6. If a disability claimant is a Veteran who has applied for Social Security Disability or SSI Benefits, must my VA Doctor assist that claimant in completing paperwork helpful to my Social Security Disability or SSI case?**

Yes. According to VA Directive, a claimant's VA physician is mandated by VA Directive 2008-071 to render assistance to the claimant in completing forms that will assist the claimant in his petition for Social Security Benefits and benefits through other Federal programs.

To view or download a copy of VA Directive 2008-071, please refer to the appendix.

**7. What is the General Analytical Framework for considering a Social Security Disability claim?**

The following is the legal analytical framework for accepting or rejecting a Social Security disability claim:

1. Does the claimant presently or did her/she during period of disability earn wages of $940 or more?

At step one the ALJ must determine whether the claimant is engaging in substantial gainful activity (20CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as work activity that is both substantial and gainful. If an individual engages in SGA, that individual is not disabled regardless of how severe that individual's physical or mental impairments are and regardless of age, education, and work experience. If an individual is not engaging in SGA, the analysis proceeds to the second step.

2. Is there anything medically wrong with the claimant that interferes with his/her ability to work?

At step two, the ALJ must determine whether the claimant has a medically determinable impairment that is "severe" or a combination of impairments that is "severe" (20CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits the individual's ability to perform basic work activities. If the claimant does not have a severe medically determinable impairment or combination of impairments, the claimant is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

3. Does any or do several of the impairments meet a listing?

At step three, the ALJ must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526(d), 416.925, and 416.909). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement (20 CFR Part 404, Subpart P. Appendix 1 (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

4. What is the claimant able and not able to do, given his/her mental and physical limitations? Can he/she do his/her past jobs?

Past jobs go back 15 years from the onset date and are only jobs that the claimant did long enough to be able to master them. A simple job generally does not take long to master (a few months), while a complex one does.
Before considering step four of the sequential evaluation process, the ALJ must first determine the claimant's residual functional capacity (20 CFR 404.1520(e) and 416.920(e)). An individual's residual functional capacity is the individual's ability to do physical and mental work activities on a substantial basis despite limitations from the individual's impairments. In making this finding, the ALJ must consider all of the claimant's impairments, including impairments that are not severe. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p)
Next, the ALJ must determine at step four whether the claimant has the residual functional capacity to perform the requirements of the claimant's past relevant work (20 CFR 404.1520(f) and 416.920(f)). If the claimant has the residual functional capacity to

do the claimant's past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

5. In light of the residual functional capacity described above, since the Claimant cannot do his/her past work, what jobs can the Claimant perform?

This area concerns vocational expertise. If a claimant has past relevant work in a given exterional category, then to get disability benefits, the claimant must not be capable of performing work in that extertional category, given his/her age, education and work experience. There are definitions for physical exertional categories and they apply whenever the claimant has a physical impairment. The code of federal regulations (CFR) 20 CFR §416.967, describes these physical exertion requirements as follows:

Physical exertion requirements:
To determine the physical exertion requirements of work in the national economy, we classify jobs as sedentary, light, medium, heavy, and very heavy. These terms have the same meaning as they have in the Dictionary of Occupational Titles, published by the Department of Labor. In making disability determinations under this subpart, we use the following definitions:

1. Sedentary work. Sedentary work involves lifting no more than 10 pounds at a time and occasionally lifting or carrying articles like docket files, ledgers, and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

2. Light work. Light work involves lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time.

3. Medium work. Medium work involves lifting no more than 50 pounds at a time with frequent lifting or carrying of objects weighing up to 25 pounds. If someone can do medium work, we determine that he or she can also do sedentary and light work.

4. Heavy work. Heavy work involves lifting no more than 100 pounds at a time with frequent lifting or carrying of objects weighing up to 50 pounds. If someone can do heavy work, we determine that he or she can also do medium, light, and sedentary work.

5. Very heavy work. Very heavy work involves lifting objects weighing more than 100 pounds at a time with frequent lifting or carrying of objects weighing 50 pounds or more. If someone can do very heavy work, we determine that he or she can also do heavy, medium, light, and sedentary work.

Generally, but not always, to get disability benefits, a person whose condition does not meet a listing must show that he/she is not capable of performing a sedentary work on a full time basis. Older people, those 50 and over, may be able to get benefits with the ability to work at light levels, depending on age, education, work history, and whether they learned any skills that could be used in other jobs (what is referred to as transferability of job skills).

Mental impairments limitations:
These impairments consider a completely different set of circumstances. The CFR describes the limitations generally as follows: "A limited ability to carry out certain mental activities, such as limitations in understanding, remembering, and carrying out instructions, and in responding appropriately to supervision, co-workers, and work pressures in a work setting, may reduce your ability to do past work and other work." 20 C.F.R. §404.1545(c). The various limitations described in the mental residual functional capacity questionnaires address these limitations. The ability to function in the following categories is weighed: 1) activities of daily living (grooming, getting to and from work, ability to shop for food, maintain a household); 2) social functioning (ability to get along with and interact with people); 3) concentration, persistence and pace (ability to pay attention to work instructions and requirements); 4) episode of decompensation (hospitalizations, times when person is unable to leave home due to mental illness). An important factor for many claimants is the ability to maintain concentration, persistence and pace, but all factors should be considered.

At the last step of the sequential evaluation process (20 CRF 404.1520(g) and 416.920(g), the ALJ must determine whether the claimant is able to do any other work considering the claimant's residual functional capacity, age, education, and work experience. If the claimant is able to do other work, the claimant is not disabled. If the claimant is able to do other work and meets the duration requirement, the claimant is not disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given the residual functional capacity, age, education, and work experience (20 CFR 404.1512(g), 404.156(c), 416.912(g), and 416.960(c)).

## 8. Is "disability" a medical determination?

Yes. A claimant may be entitled to SSDI or SSI if he or she meets a Medical Listing. The Medical listings are specific listings of impairments and are set forth in the Social Security's Guide named Disability Evaluation Under Social Security. This guide is comprised of over two hundred and fifty pages of listed conditions and the criteria for meeting a listed medical condition. The conditions include Musculoskeletal System, Special Senses and Speech, Respiratory System, Cardiovascular and Digestive Systems, Genito-Urinary System, Hemic and Lymphatic Systems, Skin, Endocrine System, Multiple Body Systems, Neurological Disorders, Mental Disorders, Neoplastic Diseases, Malignancies and Disorders of the Immune System. These Systems shall be discussed further infra as to specific information and opinions sought to effectively determine whether a claimant will qualify for disability under any of the rubrics aforesaid.

No. "Disability" is an Administrative determination, not a medical one. Life would be just too easy if a physician were to write a note that a claimant was "disabled" so he or she could get deserved benefits. It would not be right either because some people can afford doctors who may want to help by writing such things and some people, especially the rural poor, cannot.

By way of analogy, such a system would be like having a forensic pathologist come onto the stand in a homicide case and testifying before the jury that the defendant's DNA was found at the scene of the crime and that the defendant was guilty. Then the doctor would pronounce sentence, lead the poor defendant out of the courtroom, and then pull the switch, much to the astonishment of the judge and the jury.

In both cases there are laws, due process and notions of equality and fairness involved. That is why doctors are asked to give opinions on medical issues and the sorts of limitations that the claimant has or can be expected reasonably to have based on his or her diagnostic test results and clinical findings. Judges depend heavily on such things in coming to a sound and well reasoned conclusion as to why one claimant may be disabled and why another may not be. A physician's writing that a claimant is "disabled" is ignored and may actually cause an ALJ some ira, as the determination is the judge's to make by law. The statement that the claimant "is prohibited by his/her medical condition from engaging in either full time or interrupted part time employment" and a statement of the reasons, therefore, will hold great weight if such a statement comes from a treating physician. We highly recommend the use of this language and supportive content, rather than simply saying or writing that a claimant is "disabled."

Finally, since a determination of disability requires vocational and earnings calculations and analysis, physicians, unless they have a graduate degree in Vocational Evaluation, cannot give an expert opinion in these regards. For example, if I am an attorney and am blind in one eye, have no leg, am missing four fingers, and have a bad back requiring me to be wheelchair bound, one might say I was disabled; however, if I am able to earn pay in excess of SGA levels, I am not disabled even though I can only work, lets say ten hours per month. That is why "disability" is wisely left to the province of a judge, else wise, there would be too many attorneys collecting SSDI benefits.

**9. If disability is not per se a medical determination what issues will the court consider in a Social Security Disability case to decide if a person is disabled or not?**

The issue before the court in a Social Security disability case will be whether the Claimant is "disabled" within the meaning of the Social Security Act, Sections 216(i), 223(d) and 1614(a)(3)(A) as amended. "Disability" is defined as the "inability to engage in any substantial gainful employment by reason of any medically determinable physical or mental impairment or combination of impairments that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months."

With respect to the claim for a period of disability and disability insurance benefits, there may be an issue as to whether the insured status requirements of sections 216(i) and 223 of the Social Security Act are met. The claimant's earnings record must show that the claimant has acquired sufficient quarters ("Date Last Insured, or, DLI") to remain insured through at least the claimant's alleged date of onset of disability.

**10. If a physician writes that a claimant was unable to work full time at any employment from a date certain how is that relevant to his or her claim?**

The date a claimant was last able to work from a medical standpoint is important as a claimant may only be insured for disability benefits for a few years after he or she stops working. A claimant's DLI is his/her "Date Last insured." This means the date a claimant was last insured for SSDI benefits. If one is found disabled prior to the DLI, he or she will be eligible for SSDI benefits. If found disabled after the DLI, SSI benefits (i.e., welfare for the disabled paid at very low amounts) are the only form of monetary disability benefits to which a claimant may be entitled. If a claimant is entitled to at least one dollar of SSDI or SSI benefits, he or she will qualify for Medicaid benefits for the first two years of disability and for Medicare benefits thereafter.

**11. If "disability" is not a medical determination, but an administrative one, what law will apply in a Social Security disability case?**

Under the authority of the Social Security Act, the Social Security Administration has established a five-step sequential evaluation process for determining whether an individual is disabled (20CFR 404.1520(a) and 416.920(a)). The steps are followed in order. If it is determined that the claimant is or is not disabled at a step of the evaluation process, the evaluation will not go on to the next step.

**12. What happens at step 1 of the sequential evaluation process?**

At step one the ALJ must determine whether the claimant is engaging in substantial gainful activity (20CFR 404.1520(b) and 416.920(b)). Substantial gainful activity (SGA) is defined as "work activity that is both substantial and gainful. If an individual engages in SGA, that individual is not disabled regardless of how severe that individual's physical or mental impairments are and regardless of age, education, and work experience." If an individual is not engaging in SGA, the analysis proceeds to the second step.

**13. What happens at step 2 in the sequential evaluation process?**

At step two, the ALJ must determine whether the claimant has a medically-determinable impairment that is "severe" or a combination of impairments that is "severe" (20CFR 404.1520(c) and 416.920(c)). An impairment or combination of impairments is "severe" within the meaning of the regulations if it significantly limits the individual's ability to perform basic work activities. If the claimant does not have a severe medically-determinable impairment or combination of impairments, the claimant is not disabled. If the claimant has a severe impairment or combination of impairments, the analysis proceeds to the third step.

**14. What happens at step 3 in the sequential evaluation process and is a medical opinion relevant here?**

Yes. This issue needs to be addressed, at least briefly here and a further description will be found further on in this section. Suffice to say for now that at step three, the ALJ must determine whether the claimant's impairment or combination of impairments meets or medically equals the criteria of an impairment listed in 20 CFR Part 404, Subpart P, Appendix 1 (20 CFR 404.1520(d), 404.1525, 404.1526(d), 416.925, and 416.909). If the claimant's impairment or combination of impairments meets or medically equals the criteria of a listing and meets the duration requirement of 12 months or more,(20 CFR Part 404, Subpart P. Appendix 1 (20 CFR 404.1509 and 416.909), the claimant is disabled. If it does not, the analysis proceeds to the next step.

**15. Must an ALJ consider anything before continuing onto step 4 in the sequential evaluation process?**

Before considering step four of the sequential evaluation process, the ALJ must first determine the claimant's residual functional capacity (20 CFR 404.1520(e) and 416.920(e)).

**16. What is Residual Functional Capacity as used by the Social Security Administration?**

An individual's "residual functional capacity" or RFC is the individual's ability to do physical and mental work activities on a substantial basis despite limitations from the individual's impairments. In making this finding, the ALJ must consider all of the claimant's impairments, including impairments that are not severe. (20 CFR 404.1520(e), 404.1545, 416.920(e), and 416.945; SSR 96-8p)

**17. How is RFC determined and is this where a physician can be of any aid?**

Yes. A claimant's RFC is based in great part on what a treating physician may say or write about what a claimant can or cannot do. How long can he or she sit, stand or walk without having to move to avoid pain; how much a claimant can lift, especially in a competitive work environment; how often will the claimant's condition interfere with his attendance at work or interfere with his or her working a normal work day or week without symptomatic interruption or the need for medical treatment. The important information sought is set out below in our RFC section.

**18. What happens at step 4 of the sequential evaluation process?**

Next, the ALJ must determine at step four whether the claimant has the residual functional capacity to perform the requirements of the claimant's "past relevant work" (20 CFR 404.1520(f) and 416.920(f)). If the claimant has the residual functional capacity to do the claimant's past relevant work, the claimant is not disabled. If the claimant is unable to do any past relevant work or does not have any past relevant work, the analysis proceeds to the fifth and last step.

**19. What is "Past Relevant Work"?**

Past relevant work is work that the claimant has done in the past for more than three months at a full time capacity for wages or remuneration.

**20. What happens at step 5 of the sequential evaluation process?**

At the last step of the sequential evaluation process (20 CRF 404.1520(g) and 416.920(g), the ALJ must determine whether the claimant is able to do any other work considering the claimant's residual mental and/or physical functional capacity, age, education, and work experience. If the claimant is able to do other work, the claimant is not disabled. If the claimant is able to do other work and meets the duration requirement, the claimant is not disabled. Although the claimant generally continues to have the burden of proving disability at this step, a limited burden of going forward with the evidence shifts to the Social Security Administration. In order to support a finding that an individual is not

disabled at this step, the Social Security Administration is responsible for providing evidence that demonstrates that other work exists in significant numbers in the national economy that the claimant can do, given his or her residual functional capacity, age, education, and work experience (20 CFR 404.1512(g), 404.156(c), 416.912(g), and 416.960(c)).

**21. Why the national economy?**

The National economy is used because the SSA governs a national program where it is presumed that labor will follow capital to and for work if it is available in significant numbers within the United States' borders. So, if you live in a rural area and are disabled because you cannot find work that you can do, but if there were jobs like surveillance system monitors, gate guards, parking lot attendants or garment sorters in Chicago, Miami, New York, Los Angeles, then the law requires you to move to such places to find work within your residual functional capacity.

**22. What generally does the court consider in evaluating a case?**

The judge will consider when a claimant was born and his or her years of age; education that may either consists of a high school graduate, less than high school education; and whether the claimant is literate, or illiterate in English; and age at the time the present claim was filed. The judge will also consider the claimant's RFC and whether a claimant has special education or training or schooling that would create skills or learning that could be used by the claimant in another occupation within his or her RFC. The judge will also consider whether the claimant has a consistent or inconsistent past earnings history. An insignificant earnings history, unless otherwise adequately explained is somewhat detrimental to a finding of disabled in a disability case.

The judge will also consider whether the claimant has or has not engaged in substantial gainful activity since the claimant's alleged onset date, presumably the date upon which the claimant stopped work.

**23. What about earnings subsequent to the filing of a disability claim?**

As part of his or her analysis of your disability claim, the judge will also consider whether the claimant has received income subsequent to the alleged onset date and whether that is SGA or an Unsuccessful Return to SGA, or an EPE (Extended period of Earnings)

**24. What is an "Extended Period of Earnings"?**

An "Extended Period of Earnings" (EPE) is a period in which a disabled person may return to work and remain disabled and earn as much as he or she can. If earnings are substantial they may offset SSDI/SSI benefits received. In no case can an EPE extend beyond three years.

**25. Will the judge consider a claimant's mental or psychiatric condition in determining if I am disabled or not?**

Yes. The judge will also consider whether the claimant suffers primarily from the following physical or mental impairments which are considered severe under Appendix 1 to subpart P or Part 404 of 20 CFR and from depression, or anxiety, or other conditions that are severe enough to interfere with the claimant's activities of daily life and preclude the claimant from substantial gainful activity and/or full time employment or its equivalent.

It is hoped that the evidence in a case will show that the claimant cannot and could not perform sustained work activities in a competitive work environment and as a result thereof; is disabled now and was disabled at the time of the date upon which the Claimant has alleged the claimant was disabled.

**26. Will the judge consider whether a claimant meets a Medical listing?**

Yes, a medical listing is the simplest and most expedient way for a judge to determine whether a claimant is disabled. If a claimant's illness is so severe that is listed and the level of severity is met as founds in the Listing of Impairments, the judge may direct a finding of disabled pursuant to a Medical Listing. Finding that a claimant meets a listed impairment is the most expedient and secure way the SSA can make a determination of impairment and thereby circumvent the necessity for hearing and award benefits in a timely fashion.

**27. Besides a Medical Listing, is there some other way for a claimant to get disability benefits?**

Yes. A judge may award benefits also pursuant to a Vocational Rule number commonly known as "The Grids," or Social Security Ruling Number, known euphemistically as "SSRs."

**28. If the judge does not find that a claimant meets a Medical, Vocational or Social Security Rule listing, can a claimant still be found disabled?**

Yes, Should a medically determinable impairment not be found by the Court to meet a listed impairment, the claimant's impairment or combination of impairments may be considered the medical equivalent of a listed impairment, as they have the level of severity that meets or equals the criteria of the listings and result in a residual functional capacity that is so restrictive or reduced that such a residual functional capacity would not enable the claimant to engage in substantial gainful activity.

**29. What about a claimant's work background; what will the judge consider?**

The judge will consider the last grade the claimant completed and whether the claimant has past relevant work, work that was done full time for more than three months at a time for which the claimant was paid.

The judge will consider whether the claimant was last employed; how the work was performed by the claimant at skilled, semi-skilled, unskilled work; and whether the work was done by the claimant at the sedentary, light, medium or heavy exertional level. The judge will also consider whether the claimant's skills are transferable, not a material factor in the determination of the claimant's disability.

Ultimately, the judge must conclude that as of the date claimed by the claimant as the onset of the claimant's disability, the claimant was no longer able to perform the regular tasks of the claimant's previous occupation. Unfortunately, the analysis does not end there.

**30. What about a claimant's past and present medical care and treatment, does the judge have to consider that?**

The judge must determine whether the claimant has received medical evaluations and/or treatment for the conditions underlying the claimant's disability and the medical records and exhibits within the Medical or AF@ Section of the claimant's claim file that document that the claimant has medically severe impairments. That is why we encourage our clients to get continuing medical care in any way they can get it from reliable sources. Medical opinions without treatment notes that substantiate treatment and care are not given much weight by the ALJ or SSA.

**31. Does it matter that a claimant cannot afford medical treatment because he or she is poor?**

Yes. The judge must consider whether a claimant has been unable to maintain or undergo adequate continuing medical care and adequate treatment due to lack of funds sufficient for said medical care. Often, self represented claimants do not know this and it

is not brought out at their hearing, and their claims fail because of the fact that there is an unexplained lack of ongoing medical care

**32. Does the judge have to take into consideration a claimant's residual functional capacity, physical, postural and exertional limitations at the hearing?**

Yes, he or she should. The record should show that a claimant has some Residual Functional Capacity. At our offices, for our clients we use a residual physical functional capacity Questionnaire dated and completed by the claimant's treating physician, an examining physician, or even a non-examining physician, to document and confirm that the claimant has the conditions or restrictions and resultant residual physical incapacity. According to the reporting physician, the nature, frequency, and length of contact with the claimant is described along with the claimant's diagnosis, the claimant's prognosis and the claimant's symptoms, including pain, dizziness, fatigue, etc., We also have the physician determine how the claimant's pain was characterized in the nature, location, frequency, precipitating factors, and severity based on clinical findings and objective signs.

We have the doctor described the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, and whether the claimant's impairments either lasted or could be expected to last at least twelve months. We have the doctor also state whether the claimant is or is not a malingerer and whether emotional factors contribute to the severity of the claimant's symptoms and functional limitations. These are important considerations in your case. We ask the responding physician to identify any psychological conditions affecting the claimant's physical condition to see it they include depression, somatoform disorder, anxiety, personality disorder, or other impediments to work.

The reporting physician further is asked to opine whether the claimant's impairments (physical impairments plus any emotional impairments) were reasonably consistent with the symptoms and functional limitations described in the evaluation and further whether during a typical workday the claimant would frequently or constantly experience of pain or other symptoms that would be severe enough to interfere with attention and concentration needed to perform even simple work tasks, a very important consideration in your disability case. Note: "frequently" is described to mean 34% to 66% of an 8-hour working day.

**33. Does stress matter in a claimant's disability case?**

Yes. With reference to a claimant's capability to endure stress, stress matters. In our RFCs we ask our responding physician's opinion as to whether the claimant is: incapable of even "low stress" jobs, capable of low stress jobs, capable of jobs involving moderate

stress, or capable of high stress work. We ask the physician to explain the reasons for these conclusions to further strengthen his/her opinion.

**34. What about what a claimant can or cannot do in a competitive work situation?**

As a result of the claimant's impairments, we request our client's physician to further opine that if the claimant were placed in a competitive work situation, what would his or her limitations be. For example, how long can the claimant walk? How many minutes, or city blocks, without rest or severe pain, and how long the claimant could sit at one time before needing to get up? We ask how long the claimant could stand before needing to sit down, walk around, etc., and how long the claimant could sit at one time without having to get up and finally. We also ask the physician to evaluate the total time of stand/sit/walk in an 8-hour working day (with normal breaks) as this effects sustained employment situations. We also ask whether our claimant would need to include periods of walking around during an 8-hour working day and how often that this would happen and at what frequency of that the claimant (on average) would have to rest before returning to work. Again, these are important opinions to have in determining whether there are any jobs out there in the national economy that the claimant could reasonably do. It is also important that the responding physician opine whether or not a claimant would need a job that permitted shifting positions at will from sitting, standing or walking and would or would not sometimes need to take unscheduled breaks during an 8-hour working day, and how often that this would happen and at what frequency and the duration of time that the claimant (on average) would have to rest before returning to work.

Because there are so few jobs available in the national economy that allow employees to work with restrictive limitations it is also important for a reliable physician to opine that with prolonged sitting, the claimant's leg(s) need to be elevated and as to how high should the leg(s) be elevated and what percent of an 8 hour work day this restriction would apply. This is especially important for diabetics with foot problems, people with lower extremity lesions or surgeries that have failed to be cured with surgery or people with failed back syndromes and arthritic knees.

Additionally, if the physician who is so kind as to complete one of our questionnaires also sets additional postural limitations, or If the reporting physician opined that while engaging in occasional standing/walking, the claimant would have to use a cane or other assistive device, so much the better for proving the disability case, as the use of a cane denotes a person who has trouble walking up steps and across sandy or uneven surfaces and who cannot walk long distances. If crutches or two canes are necessary, the claimant's residual use of his/her hands may be impaired, as well further compelling a determination of disability.

**35. Will the judge consider a claimant's reasonably imposed lifting restrictions?**

Yes. The judge and hopefully the claimant's treating physician will opine as to weights a claimant can lift occasionally, rarely, or frequently. The judge will consider whether the Claimant could never, rarely, occasionally, or frequently lift and carry less than 10 lbs, 10 lbs, 20 lbs, or 50 lbs. in a competitive work situation.

**36. Why would the ALJ consider the restrictions a treating physician might give? I'm not a "Disability Specialist."**

A treating physician need not be a disability expert to impose reasonable restrictions on a patient. The judge and hopefully a reporting physician will opine that the claimant could further: never, rarely, occasionally, frequently, look down (sustained flexion of neck), turn his/her head right or left, look up or hold his/her head in static position; and be able to twist, be able to crouch/squat, be able to climb ladders, and be able to climb stairs. The judge will also have to determine that the claimant would have significant limitations with reaching, handling, or fingering and indicated as a consequence thereof that the percentage of time during an 8-hour working day that the claimant had limited use hands/fingers/arms to grasp, turn, and twist objects on the right and left side.

**37. What if a claimant has good days and bad days, does that come into play in a Social Security disability case?**

Yes. The judge will consider testimony and opinions from a treating physician if the attorney gets these opinions into evidence. Claimants will have good and bad days, so whether a claimant will have good days and bad ones is an important consideration especially if the treating physician can corroborate this based on the claimant's presentation and clinical appearances over time. We ask our reporting physician to opine that the claimant's impairments are likely to produce "good days" and "bad days" and estimate on average that the claimant would likely be absent from work as a result of the impairments or treatment. The claimant's number of absences due to the impairment and treatment is an important consideration for the judge, as "disability" is a vocational determination and unfortunately, not a medical one. If a claimant is absent two or more days per month due to medically, psychiatrically related issues or a need for treatment, two days or more is not therefore vocationally within standard industrial tolerances, which on the average has been traditionally once but fewer than twice per month.

A reporting physician who also describes other limitations that would affect the claimant's ability to work at a regular job on a sustained basis is very helpful to our cases.

Finally, since your date of disability must be supported by competent medical evidence of record and objective findings of record, we find it helpful for a physician to further opine as to the earliest date that the description of symptoms and limitations in the completed

questionnaire would apply, since that will help establish the date the claimant's symptoms were so severe, he would be entitled to an administrative determination of being "disabled."

**38. As a physician, I treat patients. Don't these RFCs have to be completed by a Social Security doctor or as a consequence of "Functional Capacity Evaluations" done at testing facilities?**

No. The rules of the Social Security Administration explicitly give a claimant's treating physician not only the permission to complete these forms but give the forms conscientiously completed by the claimant's treating physician "Great Weight" in determining whether or not the claimant is disabled. Functional capacity testing at an outside facility is not necessary and is not engaged in by the SSA. One of the reasons is that these tests are performed by people who are not physicians and who may have a subjective predeliction toward weighing the results and by rendering an opinion that, though "technical," is not a medical one. In the past, before the number of ALJs became too few to handle the case overload, the ALJs would send a claimant's treating physician similar questionnaires to complete. With the advent of the baby boom becoming infirm, there is just not enough time and manpower in the SSA to send these out. Unfortunately, the lack of personnel at SSA has caused the privatization of the process forcing attorneys and representatives for the claimant to do what once was a government function paid for by our tax dollars.

**39. What about non-exertional limitations, like mental impairments, are they considered in a disability case?**

Yes, a claimant's mental impairment is an important for the judge to consider as part of his or her case. Based on the claimant's psychiatric and/or psychological history, evaluations, hospitalizations, and/or other treatment records, if a claimant has a combination of psychiatric or mental impairments which are considered to be "severe" under Subpart P, Regulation No.4 of the Social Security Act, he or she may be awarded benefits. Additionally, a claimant's drug addiction and alcoholism are important if they are contributing factors material to the determination of the claimant's disability impairment, and if such drug or alcohol problem in the claimant will not meet the criteria of Section 12.04, et seq., A and B of the impairments listed in Appendix 1, Subpart P of the regulations, benefits will be denied.

**40. What good can a psychologist or psychiatrist or even a general or family practitioner who prescribes me anti-anxiety or anti-depression medications be in proving a disability case?**

Even if the strongest man in the world had a serious psychological illness, he might not be able to do even simple repetitive tasks or remember simple one or two part steps of production and as a consequence, would probably be disabled. Often we hear, "I see him and he doesn't look disabled." This is often true with those with psychological afflictions.

A GP, PCP, or family practitioner and psychiatrist or psychologist can identify the claimant as having the following signs and symptoms of anhedonia or pervasive loss of interest in almost all activities, appetite disturbance with weight change, decreased energy, thoughts of suicide, blunt, flat or inappropriate affect, feelings of guilt or worthlessness, impairment in impulse control, poverty of content of speech, generalized persistent anxiety, somatization unexplained by organic disturbance, mood disturbance, difficulty thinking or concentrating, recurrent and intrusive recollections of a traumatic experience which are a source of marked distress, psychomotor agitation or retardation, pathological dependence, passivity or agressivity, persistent disturbances of mood or affect, persistent nonorganic disturbance of vision, speech, hearing, use of a limb, movement and its control, or sensation, change in personality, apprehensive expectation, paranoid thinking or inappropriate suspiciousness, recurrent obsessions or compulsions which are a source of marked distress, seclusiveness or autistic thinking, substance dependence, incoherence, emotional withdrawal or isolation, psychological or behavioral abnormalities associated with a dysfunction of the brain with a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities, bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes), persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity or situation; intense and unstable interpersonal relationships and impulsive and damaging behavior; disorientation to time and place; perceptual or thinking disturbances, hallucinations or delusions, hyperactivity, motor tension, catatonic or other grossly disorganized behavior, emotional liability; flight of ideas; manic syndrome, deeply ingrained, maladaptive patterns of behavior; inflated self-esteem; unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury, unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury, loosening of associations; illogical thinking; pathologically inappropriate suspiciousness or hostility; pressures of speech; easy distractibility; autonomic hyperactivity; memory impairment - short, intermediate or long term; sleep disturbance, oddities of thought, perception, speech or behavior, decreased need for sleep; loss of intellectual ability of 15 IQ points or more; recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; a history of multiple physical symptoms (for which there are organic findings) of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly; involvement in activities that have a high probability of painful consequences which are not recognized.

So, if you find that you have one or more of these symptoms, you might want to get checked out by a good professional, not only for your own good, but it may be helpful in proving your disability case.

**41. Will the judge consider a claimant's ability to do work-related activities on a day-to-day basis in a regular work setting?**

Based on a doctor's examination of how the claimant's mental/emotional capabilities were affected by the impairment(s), and considering the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not the claimant's age, sex, or work experience, the judge will examine a claimant's mental abilities and aptitudes to do skilled, semi-skilled, and unskilled work.

**42. What sort of things must a physician, psychologist or psychiatrist find or will they look for in determining a claimant's aptitude and ability to do Unskilled Work?**

Part of what a judge will consider is whether you are seriously limited but not precluded or unable to meet competitive standards or have no useful ability to function in a work like setting. For example, the doctor and judge will consider a claimant's ability to remember work-like procedures, to understand and remember very short and simple instructions, to maintain attention for a two hour segment, to maintain regular attendance and be punctual within customary strict tolerances, to sustain an ordinary routine without special supervision, to work in coordination with or proximity to others without being unduly distracted, to make simple work-related decisions, to complete a normal workday and workweek without interruptions from psychologically based symptoms, to perform at a consistent pace without an unreasonable number and length of rest periods, to ask simple questions or request assistance, to accept instructions and respond appropriately to criticism from supervisors, to get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes, to respond appropriately to changes in a routine work setting, to deal with normal stress, and to be aware of normal hazards and take appropriate precautions. These are all important considerations in the administrative determination as to whether or not a claimant with a mental impairment is disabled.

**43. What about a claimant's mental abilities and aptitudes needed to do Semiskilled and Skilled Work is considered by the judge or medical expert?**

The judge or medical expert in a Social Security Disability case will consider whether a person with a psychological handicap seriously limits precludes or makes a claimant unable to meet competitive standards in a hypothetical job. They will also determine whether a claimant has any useful ability to function and the ability to understand and remember detailed and even simple instructions, meet competitive standards, and carry

out detailed instructions. They will also determine if a claimant can set realistic goals or make plans and work independently of others and deal with regular work stress or need constant supervision.

**44. What about a claimant's ability to do other types of jobs?**

The judge or physician will determine a claimant's mental abilities and aptitudes needed to do particular types of jobs. For example if a claimant is found to be unable to meet competitive standard or no useful ability to function in the ability to interact appropriately with the general public, to maintain socially appropriate behavior, to adhere to basic standards of neatness and cleanliness, in the ability to use public transportation, or to travel in unfamiliar places, it is an indicator that the claimant is probably disabled psychologically from any job that may exist in the national economy.

**45. What about a "Mental Impairment Analysis?" What is it and what does a judge look for?**

A Mental Impairment Analysis commonly known as "B" Criteria Listings, with reference to the rating of functional limitations or "B" Criteria of the Listings, the reviewing physician may indicate that the degree that the claimants functional limitations (which are found in 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) and can be found by a psychologist or psychiatrist or medical doctor to be of either Mild, Moderate, Marked*, or Extreme* difficulty or restrictions in: a claimant's activities of daily living, or in maintaining a claimant's normal social functioning or maintaining concentration, persistence, or pace.

*If these restrictions are Marked or Severe, a claimant may very well be disabled from a psychological standpoint. Moreover, if a claimant is determined to be Suffering Repeated Episodes of Decompensation, each of extended duration measured more as to frequency than to duration two or more times per year, he or she may actually meet a psychiatric medical listing and be eligible for benefits.

**46. What are "C" Criteria listings in determining if a patient is mentally disabled?**

"C" Criteria listings reflect the existence of an extremely severe mental condition. With reference to the "C" Criteria of the Listings the judge through the use of psychiatric evidence will look to see if the claimant to has or meets specific criteria. This criteria evidence that does establish the presence of the "C" criteria, to Wit., a medically documented history of a chronic organic mental (12.02), schizophrenic, etc. (12.03), or

affective (12.04) disorder 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 repeated episodes of decompression, each of extended duration, a residual disease process that has resulted in such marginal adjustment so that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate. Also to be considered is the patient's 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 or the complete inability to function independently outside the area of one's home.

**47. What are "GAF SCORES" and why are they relevant to a finding of a disability based on psychiatric grounds?**

A person's GAF can vary from patient visit to patient visit and may be relied on in part in determining a person's ability to function in the workplace. One's GAF score is a "Global Assessment of Function" numerical short hand used by mental health practitioners to document how a patient is doing over all mentally. According to the DSM IV, there are numerous ratings set forth below.

For example a GAF of (91 - 100): would reflect superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
A GAF of (81 - 90): Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an argument with family members).
A GAF of (71 - 80): If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).
A GAF of (61 - 70): Some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household) but generally functioning pretty well and has some meaningful interpersonal relationships.
A GAF of (51 - 60): Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
A GAF of (41 - 50): Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
A GAF of (31 - 40): Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood) (e.g., depressed man

avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
A GAF of (21 - 30): Behavior is considerably influenced by delusions or hallucinations or serious impairment, in communication, or judgment (e.g., stays in bed all day, no job, home or friends).
A GAF of (11 - 20): Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent, manic excitement) or occasionally fails to maintain minimal personal hygiene (e.g., smears feces) or gross impairment in communication (e.g., largely incoherent or mute).
A GAF of (1 - 10): Persistent danger or severely hurting self or others (e.g., recurrent violence) or persistent inability to maintain minimal hygiene or serious suicidal act with clear expectation of death.

**48. If a claimant is psychologically disabled, will he or she be allowed to manage his or her own money?**

Probably, but this is taken on a case by case basis. At a claimant's hearing or in his order, your judge will also opine that the claimant can or cannot manage benefits in his or her own best interest. If the claimant cannot manage his/her own funds, an alternative payee may have to be appointed. If a claimant had an alcohol or drug abuse issue, an alternate payee will be appointed most likely.

**49. Do a claimant's subjective complaints of pain have to agree with test results or clinical findings by a physician to be relevant?**

Yes generally. A claimant's complaints of pain and restriction must comport with the objective findings, medical evidence, and treatment notes and should, as a consequence thereof, be found to be credible. The claimant's testimony must be supported by objective medical evidence of a condition that can reasonably be expected to produce those symptoms of which the claimant complains and, thereby, is sufficient to sustain a finding of disability. Johns v.Bowen, 821 F.2d 551,554 (11th Cir.1987). See 42 U.S.C. sect. 423(d)(5)(A).

**50. Based on the elements of record and the claimant's statements of record and in light of the objectively documented physical and medical findings within the record if the claimant does not have the residual functional capacity to perform a full range of even sedentary work or is generally unable to sustain or maintain an eight hour workday or a forty hour work week or its equivalent on a regular and consistent basis is he or she disabled?**

Yes. Such an individual would be considered unemployed in the competitive economy so that jobs like ticket taker, parking lot attendant, gate guard, eyeglass assembler, or even a surveillance system monitor job would not be able to be performed.

**51. Based on the claimant's age, education, transferable job skills or lack thereof and based on the claimant's residual physical and mental residual functional capacity, and where the claimant is significantly unable to engage in substantial gainful activity or sustained full time employment, involving simple one or two step repetitive tasks, is such a person disabled?**

Yes, such a claimant has been under a disability, as defined in the Social Security Act.

**52. If a claimant does have an impairment or combination of impairments that meets or medically equals one of the listed impairment(s) in 20 CFR 404, Subpart P, Appendix 1 (20 CFR 404.1520(d) and 416.920(d)) is he or she disabled?**

Yes. This sort of case is the most easy to prove as long as all the proper medical or psychiatric records are gathered and filed with the Social Security Administrator.

**53. If the severity of the claimant's (mental) affective disorder impairment meets the criteria of listing section 12.04 et seq., of 20 CFR Part 404, Subpart p, Appendix (20 CFR 404.1520(d) and 404.1525) is that claimant disabled?**

Yes. Again IQ tests, Psychiatric Hospital, and treatment records must be timely filed to prove a case involving affective disorder.

**54. If, after careful consideration of the record, the judge finds that a Claimant's limitations so markedly restricted the Claimant's ability to perform even sedentary work, as defined by the regulations and result in such an erosion of the occupational base for which the Claimant would otherwise qualify that there are no jobs available in the national economy which the Claimant could perform is the claimant disabled?**

Yes. Even though jobs may actually exist for such a claimant, if the job base is sufficiently eroded (20% or more generally), that claimant would be disabled.

**55. If, after careful consideration of the record, the judge finds that a claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) and 416.967(a) with lifting no more that 10 pounds occasionally**

**and can stand/walk no more than 2 hours in an eight hour day. And sit for less than two hours of an eight hour day, would that person be disabled?**

Probably. Full time employment even at the light/ sedentary level still requires someone to work 36 hours or more per week. Anything less is not full time employment.

**56. If, after careful consideration of the record, the judge finds that a claimant has the residual functional capacity to perform sedentary work as defined in 20 CFR 404.1567(a) and 416.967(a) with lifting no more that 10 pounds occasionally and can stand/walk no more than 2 hours in an eight hour day. And sit up to six hours of an eight hour day, would that person be disabled?**

Probably. It would depend on that person's age, work experience, and transferability of job skills. The older and less literate or educated and skilled a claimant is, the more likely he or she will be found to be disabled.

**57. In making his or her decision, is there any form of analytical process the judge must use in determining whether or not the claimant may be entitled to benefits?**

Yes. In making his/her finding, the ALJ should consider all symptoms to the extent to which these symptoms can reasonably be accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 404.1529 and 416.929 and SSRs 96-4p and 96-79, In the 11th Circuit, a claimant who alleges disability on subjective complaints of pain must show evidence of an underlying medical condition, and either: (1) objective medical evidence that confirms the severity of the alleged pain from that condition; or (2) that the objectively determined medical condition is of such a severity that it can reasonably be expected to give rise to the alleged pain (Landry v. Heckler, 782 F 1551 (11th Cir. 1986)) and also consider the opinion evidence in accordance with the requirements of 20 CFR 404.1527 and 416.927 and SSRs 96-2p, 96-5p, 96-6p, and 06-3p.

**58. After considering the evidence of record, the ALJ should find that the claimant's medically determinable impairment(s) could reasonably be expected to produce the alleged symptoms and that the claimant's statements concerning the intensity, persistence, and limiting effects of these symptoms are generally credible**.

The contrary State agency medical opinions are given little weight because the State agency consultants did not adequately consider the claimant's subjective complaints of pain, which should appear credible in light of the objective and clinical findings noted above. The State agency also failed to consider the combined effect of all of the claimant's impairments, including the recent evidence submitted by the claimant.

**59. If a claimant's acquired job skills do not transfer to other occupations within the residual functional capacity as defined in (20 CFR 404.1568 and 416.966) and the claimant does not have transferable job skills that would enable the claimant to return to either regular full time employment or substantial gainful activity, is that claimant disabled?**

Yes.

**60. If considering the claimant's age, education, work experience, transferable job skills and lack thereof, if there are no jobs that exist in significant numbers in the national economy that the claimant can perform (20 C.F.R. 404.1560(c), 404.1566, 416.9608, and 416.966), is he or she considered disabled?**

Yes.

**61. What if there may be some job out there like the proverbial store greeter that my patient may be able to do, is he or she not disabled?**

I wish it were that simple. Just because one can do some job, it does not necessarily mean that one is not disabled.

In determining whether a successful adjustment to other work can be made, the ALJ must consider the claimant's residual functional capacity, age education, and work experience in conjunction with the Medical-Vocational Guidelines, 20 CFR Part 404, Subpart P, Appendix 2. If the claimant can perform all or substantially all of the exertional demands at a given level of exertion, the medical-vocational rules direct a conclusion of either "disabled" or "not disabled" depending on the claimant's specific vocational profile (SSR 83-11)

Even if the claimant had a residual functional capacity for a full range of sedentary work, considering the claimant's age, education, and work experience, a finding of "disabled" would be directed by Medical-Vocational Rule 201. 01 et seq.,

Due to the Claimant's age, vocational background, lack of transferable job skills and residual functional capacity, a disabled Claimant would be unable to make a successful adjustment to any jobs that exist in significant numbers in the national economy so as to engage in substantial gainful activity or sustained full time employment. Considering the Claimant's physical and/or mental limitations, if the Claimant cannot make and adjustment to any work that exists in significant numbers in the national economy and consequently, based on the Social Security Ruling 85-15, a finding of disabled should be reached therefore within the framework of medical-vocational rules.

Interaction and the limiting effects of his/her impairments on his/her past relevant work to determine whether the claimant could still do that work, an ALJ's decision to deny the claimant benefits because he/she could return to past relevant work and would not be supported by substantial evidence.

**62. Must an ALJ elicit testimony from a vocational expert (VE) if it is found that a claimant cannot go back to my past relevant work?**

Yes, as a consequence of a claimant being unable to return to past relevant work, an ALJ should elicit VE testimony to determine whether the claimant could perform other work. Foote v. Chater, 67 F.3d 1553 (11th Cir. 1995).

**63. What if a claimant is absent excessively or suffer from incontinence due to his or her condition, will that be considered as part of the Social Security Disability case?**

In addition to the claimant's absences and absenteeism due to her condition, the issue of the claimant's incontinence is also highly relevant to the claimant's ability to return to work and AN ALJ's failure to properly weigh and consider it can be reversible error. Incontinence can be an impairment for purposes of the being found disabled under the Social Security Act and must be considered by an ALJ in determining whether the claimant is disabled. Crowley v. Apfel, 197 F.3d 194 (5th Cir.1999). Where the record is plain that a claimant could not return to past relevant work not only due to his/her absences due to his/her nephritic condition, but also due to pain and his/her need to use the restroom frequently, benefits may well be rewarded.

**64. Does a claimant's pain really matter in a disability case?**

Yes, a claimant's subjective complaints of pain which are consistent with and supported by objective medical evidence and as such, should have been entitled to great weight, See Urtz v. Callahan, 965 F.Supp.324,328 (N.D.N.Y. 1997). The claimant's subjective complaints that are supported by the evidence should be given such deference and weight especially in light of any extensive hospital record and opinions of treating physicians that support such a conclusion. In fact an ALJ must give legitimate reasons to discredit the claimant's testimony especially where there was no suggestion of exaggeration of symptoms from the record and the claimant's treating physician supports the claimant's testimony. See, Dvorak v Celebrezze, 345 F. 2d 897 (10th Cir. 1965).

**65. Must a judge sufficiently articulate the reasons for assigning treating physicians opinions little or no weight and relying instead on parts of the opinion of**

**a non-examining medical consultant that had not examined the claimant or considered the record as a whole?**

It is axiomatic that an ALJ has a basic duty to develop a full and fair record. Brown v. Shalala, F. 3d 931,934 (11th Cir. 1995). An ALJ cannot patently ignore the opinions of treating physicians and decide that a claimant is not disabled essentially based on the opinion of one non-examining state evaluator. It is well established that the opinion, diagnosis, and medical evidence of a Plaintiff's treating physician should be accorded substantial weight unless "good cause" is shown for not doing so. Bloodworth v. Heckler, 703 F.2d 1233 (11th Cir. 1983). Moreover, where the opinions of the claimant's treating physicians are consistent with the substantial evidence of record that shows a claimant to be disabled, and truly no "good cause" is shown by an ALJ in his opinion to disregard the opinions of the Plaintiff's treating physicians in light of the medical record established in the case, the ALJ commits error since reports from non-examining advisors cannot by themselves "trump the findings" from treating physicians, Weiler v. Shalala, 922 F. Supp. 689, (D. Mass. 1996), and cannot by itself constitute substantial evidence that justifies the rejection of the of the opinion of an examining or treating physician, Morgan v. Comm'r of the Soc. Sec.Admina., 169 F.3d 595 (9th Cir. 1999). In the face of overwhelming record evidence of disability, the findings of a non-examining reviewing doctors are given little weight. See, Lamb v. Bowen, 847, F.2d 698 (11th Cir. 1988) and Simmons v. U.S. R.R. Retirement Board., 982 F.2d 49, (2d Cir. 1987), a judge's decision to give more weight to the opinion of a non-treating, non-examining source than to those of the claimant's treating doctors in a case is error especially since it does not rest on the substantial evidence of record. See, Rosario v. Apfel, 85 F.Supp.2d 62,(D. Mass. 2000)

**66. Will a claimant's own physician's opinions that are consistent with the claimant's treatment record be given controlling weight in his or her disability case?**

Yes, the claimant's treating physicians' opinions in a case should be given controlling weight especially when they are well supported by medically acceptable clinical and laboratory diagnostic techniques, the clinical presentation of the claimant and her testimony and are not inconsistent with other substantial evidence in this case. See, Peterson v. Chater, 983 F. Supp.1410 (M.D. Fla. 1977). Having failed to adequately refute a claimant's treating physician's opinions and reports, the findings in those reports are to be accepted as true as a matter of law. MacGregor v. Bowen, 786 F.2d 1050, (11th Cir. 1986) and should be, in light of the fact that the reports of state agency advisors in a case may be unsigned and cannot be used to deny benefits. See, Roman v Apfel, 24 F. Supp. 2d 263 (D. Conn. 1998).

**67. Must an ALJ develop a full and fair record and take into account the claimant's medical history, absenteeism, and pain in assessing a claimant's residual functional capacity?**

Yes. It has long been the law that an ALJ must scrupulously and consciously probe into, inquire of and explore all relevant facts. Cowart v. Schweiker, 662 F.2d 731, 735 (11th Cir. 1995). An ALJ errs by failing in his duty to consider all impairments in evaluating the claimant's disability Walker v. Bowen, 826 F.2d 996-1001 (11th Cir. 1987).

**68. Must an ALJ consider ALL of a claimant's limitations?**

Yes, the ALJ is required to consider and include all of the limitations that are well documented in the record of the claim. An ALJ cannot pick and choose from evidence in the record, but must consider all of the evidence as a whole, Loza v. Apfel, 219 F. 3d 378,394 (5th Cir. 2000). Where an ALJ bases his entire decision on selective excerpts from one medical source while ignoring others, he errs by violating the requirements set forth in Crawford v. Commissioner, 363 F.3d 1155 (11th Cir. 2004) and Ziegler v. Barnhart, 278 F. Supp. 2d 1331 (M.D.Fla.2003), where an ALJ failed to accord the opinion of treating physicians great weight and failed to show good cause to the contrary. As a consequence the ALJ's decision to deny the claimant benefits was reversed.

**69. Must an ALJ consider or address the side effects of a claimant's medications on his or her employability?**

Yes, an ALJ must consider both precipitating and aggravating factors of your disability and the type, dosage, effectiveness, and side effects of medications. So, you may want to say that "the ALJ failed to properly evaluate and consider both precipitating and aggravating factors of my disability and the type, dosage and effectiveness of my medications."

Or "The ALJ erred in failing to take into account the effect of medications on claimant's residual functional capacity in determining disability, in violating of SSR 96-7."

**70. What if the ALJ fails to consider the claimant's need for medical care and treatment that will occur on a regular basis, or the absences he or she will probably have for this medical care or just being too sick to work a few days or more per month due to sickness?**

The ALJ must consider these things in his or her decision. Many a successful appeal of a judge's decision denying benefits has asserted that "The ALJ failed to consider the claimant's need to accommodate his/her physical and/or mentally related symptoms, need for medical treatment and absences related to symptoms and/or medical treatment."

**71. What is the claimant's burden to prove in his or her disability case?**

Once a claimant has proven that the claimant's impairments render him or her unable to perform past work, the burden shifts to show that there is other gainful work in the national economy which the claimant can perform. Venette v. Apfel, 14 F. Supp 2d 1307, 1312 (S.D. Fla. 1998), citing 20 C.F.R. Section 404.1520(e)(f).

**72. Once a claimant meets the burden, does the burden shift to the government and how does the SSA go about showing that a claimant is not disabled?**

Yes, once the burden shifts, this requires the testimony of a vocational expert, who is either present or testifies at the claimant's hearing. Testimony from a vocational expert is "highly valued and commonly obtained in order to establish the availability of suitable alternative jobs for disability claimants." Holley v. Chater, 931 F. Supp. 840, 851 (S.D> Fla. 1996), and is, in fact, necessary to determine whether there is other work available in the national economy that the claimant can do. See Wiloson v. Chater, 76 F. 3d 238, 241 n4. (8th Cir. 1996). Procedurally, once the claimant has proved that she could not return to past relevant work, a judge may err by failing to produce or consider VE testimony which if adduced at hearing would have supported the proposition that considering the nature of a claimant's illness, requirements for example, for use of the bathroom and numerous yearly absences, a VE would have likely conclude that a claimant was probably unable to work at all at the SGA level. See, Caviness v. Apfel, 4F. Supp2d 813 at 825 (S.D. Ind. 1998) See also, Moore v. Halter, 168 F. Supp. 2d 1137, (N.D. Cal. 2001) (where the court found that the ALJ erred in failing to properly consider the claimant's limitation of requiring 10 restroom trips in a workday and to discuss these details with a vocational expert).

**72. What if a claimant's pain or depression prevents a claimant from concentrating on simple one or two step tasks throughout the day, is that something the ALJ has to consider if a claimant testifies about it or his or her doctors have written about this and those reports are in the record?**

The ALJ must take into consideration any deficits a claimant may have in memory, focus, concentration, persistence or pace. If a claimant does testify about this or if the physicians have written about this and it is part of your record, he or she would probably allege on appeal that "The ALJ erred in failing to take into account my limitations in the ability to maintain attention, concentration and pace in assessing my residual functional capacity or through the questioning of the vocational expert."

**73. If a claimant suffers from obesity and it is not his or her primary disabling condition, must the ALJ consider the effects of obesity on residual physical capacity in determining if the claimant is disabled or not?**

An ALJ must consider obesity and its overall impact on a claimant's ability to work. If the ALJ failed to take obesity into consideration in his denial of benefits, the ALJ may be reversed if it is found that "The ALJ failed to take into consideration the Claimant's obesity and its effects on the Claimants Residual Functional Capacity." Otherwise, if Obesity is the primary cause of a claimant not being able to engage in SGA, then his or her benefits are rightfully denied by effect of law.

**74. What if a claimant has fibromyalgia; what must a judge or physician find if he or she is to be eligible for SSI or disability benefits?**

Fibromyalgia is a disease that interferes with a claimant's functional capacity. A rheumatologist is the best type of doctor for the claimant to see and with whom to treat. A good doctor can diagnose, document and relate the nature, frequency and length of contact with the patient and determine whether the claimant meets the criteria of the American College of Rheumatology for the diagnosis of fibromyalgia. Such a physician would have to opine that the patient's impairments have lasted or can be expected to last at least twelve months and clinically identify and document all of the patient's symptoms like multiple tender points, non-restorative sleep, chronic fatigue, morning stiffness, muscle weakness, subjective swelling, numbness and tingling, breathlessness, anxiety, and depression.

A good rheumatologist can also opine that certain emotional factors contribute to the severity of the patient's symptoms and functional limitations inclusive of the spine, chest, legs, hands, and arms. These document the nature, frequency, and severity of the patient's pain and also identify factors that would precipitate pain. A good rheumatological physician can also opine that the patient's impairments (physical impairments plus any emotional impairments) are reasonably consistent with the symptoms and functional limitations described in his or her evaluation and determine how long during a typical workday the patient's experience of pain or other symptoms would be severe enough to occasionally, frequently, or constantly interfere with attention and concentration needed to perform even simple work tasks and to what degree the patient would be able to tolerate work stress, and identify the side effects of the claimant's medications that may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.

As a result of the patient's impairments, a rheumatologist or other physician can estimate the patient's functional limitations if the patient were placed in a competitive work situation, for example for how long the patient could walk without rest or severe pain; sit at one time, e.g., before needing to get up, etc.; or stand at one time, e.g., before needing to sit down, walk around, etc., in an 8 hour workday (with normal breaks); or if the patient would need to include periods of walking around during an 8 hour work day, and how long or frequently this would happen each time or if the patient would need a job which permits shifting positions at will from sitting, standing or walking, and that while engaging in occasional standing/walking, the patient would need to take unscheduled

breaks during an 8-hour workday, and how often this would happen and the patient would have to rest before returning to work.

**75. What is the American College of Rheumatology's definition of Fibromyalgia?**

According to the definition of Fibromyalgia by the American College of Rheumatology (ACR), Fibromyalgia is defined as a disorder in patients as "widespread pain in all four quadrants of the body for a minimum duration of 3 months and at least 11 of the 18 specified tender points which cluster around the neck, shoulder, chest, hip, knee and elbow regions with development of other clinically documented over time." Possible symptoms include IBS, chronic headaches, TMJ, dysfunction, sleep disorder, severe fatigue, and cognitive dysfunction.

With reference to the American College of Rheumatology standards for the diagnosis of fibromyalgia as under the ACR guidelines, are as follows:

1. The patient had a history of widespread pain which includes pain on the right and left sides of the body.
2. The patient had pain above and below the waist.
3. The patient had pain (meaning a force of 4 kilograms on the tender point is "painful" and not simply "tender") in at least 11 of 18 tender point sites on digital palpation.
4. The patient's pain had been documented as "tender" and the medications the patient is on for fibromyalgia would reasonably be expected to reduce "pain" in these tender areas.
5. It was thought that should the patient should not be taken be taken off said medications.
6. The intended effects of the medication or side effects would interfere with the patient's ability to maintain attention, concentration or focus for 8 hours of an 8 hour day.

**76. Are "environmental restrictions" important to a disability case?**

Yes. If a doctor feels that the patient should avoid exposure to: extreme cold, extreme heat, wetness, humidity, noise, fumes, odors, dusts, gases, poor ventilation, and hazards (machinery, heights, etc.), it will be important to your case since it limits the places where you may be able to work.

**77. What if a claimant has Chron's Disease, IBS, and/or Colitis? What are the legal or medical considerations that a treating physician should document to help the patient's case?**

The important patient's symptoms in these areas are described as chronic diarrhea,

Malaise, bloody diarrhea, fatigue, anxiety, mucus in stool, kidney problems, loss of appetite, fever, ineffective straining at stool (rectal tenesmus), fatigue, eye problems, weight loss, pain, loss of appetite, dizziness, bowel obstruction, fatigue, vomiting, weight loss, abdominal distention, embarrassment, fistulas, abdominal pain and cramping, anal fissures, and peripheral arthritis. The clinical findings and objective signs should be identified by your physician who can also properly described the patient to have pain or episodic symptomotology, characterized by the nature, location, frequency, precipitating factors, and severity of patient's pain as described by the patient. Aspects of such a patient's impairment are episodic, and can be appropriately described in the nature, precipitating factors, inclusive of taste, smell food, drink severity, frequency and duration of the episodic and/or aspects of symptomotology by a physician.

Your doctor can also describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc.

Emotional factors can also contribute to the severity of the patient's symptoms and functional limitations. A doctor can also identify depression, anxiety, somatoform disorder, personality disorder, and other factors, as psychological conditions affected the patient's physical condition. A physician can also describe in his/ her report of response forms an opinion as to how during a typical workday the patient would be expected to experience of pain including intestinal pain, discomfort and urge to use the bathroom or other symptoms which would be severe enough to interfere with attention and concentration needed to perform even simple tasks, a very important consideration for your judge in determining how many jobs such a person could do out there in the national economy.

### 78.a. How can a minor be considered medically disabled?

A minor may have a "disability" but still may not be disabled. Under section 1614(a)(3)(C) of the Social Security Act, an individual under the age of 18 shall be considered disabled if she has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Notwithstanding the above, no individual under the age of 18 who engages in substantial gainful activity may be considered to be disabled.

### 78.b. Are a disabled child's SSI benefits payable prior to the date his or her application is filed?

Supplemental security income is not payable prior to the month following the month in which the application was filed (20 CFR 416.335).

**78.c. Under what authority can an ALJ find a child disabled?**

Under the authority of the Social Security Act, the Social Security Administration has established a three-step sequential evaluation process to determine whether an individual under the age of 18 is disabled (20 CFR 416.924(a)).

**78.d. What are the steps of analyses involved in determining whether a child is disabled?**

At step one, the ALJ must determine whether the claimant (child or adult child) is engaging in substantial gainful activity. Substantial gainful activity is defined as work activity that is both substantial and gainful. An individual is engaging in substantial gainful activity is she is doing significant physical or mental activities for pay or profit (20 CFR 416.972). Generally, if an individual has earnings from employment or self-employment above a specific level set out in the regulations, it is presumed that he/she has demonstrated the ability to engage in substantial gainful activity (20 CFR 416.974 and 416.975). If the claimant is performing substantial gainful work, he/she is not disabled regardless of his/her medical condition(s) (20 CFR 416.924(b)). If the claimant is not engaging in substantial gainful activity, the analysis proceeds to the second step.

**79.e. What is step two in determining whether a child is disabled?**

At step two, the ALJ must determine whether the claimant has a medically determinable "severe" impairment or a combination of impairments that is "severe." For an individual who has not attained age 18, a medically determinable impairment or combination of impairments is not severe if it is a slight abnormality or a combination of slight abnormalities that causes no more than minimal functional limitations. If the claimant does not have a medically determinable severe impairment(s), he/she is not disabled (20 CFR 416.924(c)). If the claimant has a severe impairment(s), the analysis proceeds to the third step.

**79.f. What does step three entail?**

At step three, the ALJ must determine whether the claimant has an impairment or combination of impairments that meets or medically equals the criteria of a listing, or that functionally equals the listings

**79.g. What must the ALJ consider?**

In making this determination, the ALJ must consider the combined effect of all medically determinable impairments, even those that are not severe (20 CFR 416.923, 416.924a(b)(4), and 416.926a(a) and (c)). If the claimant has an impairment or combination of impairments that meets, medically equals or functionally equals the listings and has lasted or is expected to last for a continuous period of at least 12 months, he/she is presumed to be disabled. If not, the claimant is not disabled (20 CFR 416.924(d)).

**79.h. What is the purpose of determining the "Six Domains" and functionally equaling a listing?**

In determining whether an impairment or combination of impairments functionally equals the listings, the ALJ must assess the claimant's functioning in terms of 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 his or herself; and (6) health and physical well-being.

**79.i. What does an ALJ have to do to make this assessment?**

In making this assessment, the ALJ must compare how appropriately, effectively and independently the claimant performs activities compared to the performance of other children of the same age who do not have impairments. To functionally equal the listings, the claimant's impairment or combination of impairments must result in "marked" limitations in two domains of functioning or an "extreme" limitation in one domain (20 CFR 416.926a(d)).

**79.j. What else does an ALJ have to consider?**

In assessing whether the claimant has "marked" or "extreme" limitations, the ALJ must consider the functional limitations from all medically determinable impairments, including any impairments that are not severe (20 CFR 416.926a(a)). The ALJ must consider the interactive and cumulative effects of the claimant's impairment or multiple impairments in any affected domain (20 CFR 416.926a(c)).

**79.k. What do you mean by a child's "marked" limitation?**

Social Security regulation 20 CFR 416.926a(e)(2) explains that a child has a "marked limitation" in a domain when her impairment(s) "interferes seriously" with the ability to independently initiate, sustain, or complete activities. A child's day-to-day functioning may be seriously limited when the impairment(s) limits only one activity or when the

interactive and cumulative effects of the impairment(s) limit several activities. The regulations also explain that a "marked" limitation also means:

1. A limitation that is "more than moderate" but "less than extreme."
2. The equivalent of functioning that would be expected on standardized testing with scores that are at least two, but less than three, standard deviations below the mean.
3. A valid score that is two standard deviations or more below the mean, but less than three standard deviations, on a comprehensive standardized test designed to measure ability or functioning in that domain, and his/her day-to-day functioning in domain-related activities is consistent with that score.
4. For the domain of health and physical well-being, frequent episodes of illnesses because of the impairment(s) or frequent exacerbations of the impairment(s) that results in significant, documented symptoms or signs that occur: (a) on an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; (b) more often than 3 times a year or once every 4 months, but not lasting for 2 weeks; or (c) less often than an average of 3 times a year or once every 4 months but lasting longer than 2 weeks, if the overall effect (based on the length of the episode(s) or its frequency) is equivalent in severity.

**80. What is an "extreme" limitation?**

Social Security regulation 20 CFR 416.926a(e)(3) explains that a child has an "extreme" limitation in a domain when her impairment(s) interferes "very seriously" with her ability to independently initiate, sustain, or complete activities. A child's day-to-day functioning may be very seriously limited when her impairment(s) limits only one activity or when the interactive and cumulative effects of her impairment(s) limit several activities. The regulations also explain that an "extreme" limitation also means:

1. A limitation that is "more than marked."
2. The equivalent of functioning that would be expected on standardized testing with scores that are at least three standard deviations below the mean.
3. A valid score that is three standard deviations or more below the mean on a comprehensive standardized test designed to measure ability or functioning in that domain, and her day-to-day functioning in domain-related activities is consistent with that score.
4. For the domain of health and physical well-being, episodes of illness or exacerbations that result in significant, documented symptoms, or signs substantially in excess of the requirements for showing a "marked" limitation.

**80.a. What must an ALJ do to determine the degree of limitations in each of the "six functional domains"?**

In determining the degree of limitation in each of the six functional domains the ALJ has to consider all symptoms and the extent to which these symptoms can reasonably be

accepted as consistent with the objective medical evidence and other evidence, based on the requirements of 20 CFR 416.929, SSRs 96-4p and 96-7p. The ALJ has to also consider the opinion evidence in accordance with 20 CFR 416.927 and SSRs 96-2p, 96-5, 96-6p and 06-3p.

### 81. How does an ALJ evaluate a child claimant's symptoms?

In considering a claimant's symptoms, the ALJ must follow a two-step process in which it must first be determined whether there is an underlying medically determinable physical or mental impairment(s)—i.e., an impairment(s) that can be shown by medically acceptable clinical and laboratory diagnostic techniques—that could reasonably be expected to produce the claimant's pain or other symptoms.

Second, once an underlying physical or mental impairment(s) that could reasonably be expected to produce the claimant's pain or other symptoms has been shown, the ALJ must evaluate the intensity, persistence, and limiting effects of the claimant's symptoms to determine the extent to which they limit the claimant's ability to do basic work activities. For this purpose, whenever statements about the intensity, persistence, or functionally limiting effects of pain or other symptoms are not substantiated by objective medical evidence, the ALJ must make a finding on the credibility of the statements based on a consideration of the entire case record.

For example, after considering the evidence of record, the ALJ finds that a claimant's medically determinable impairments could reasonably be expected to produce the alleged symptoms; however, the statements concerning the intensity, persistence and limiting effects of the claimant's symptoms are no credible to the extent that they are inconsistent with finding that the claimant does not have an impairment or combination of impairments that functionally equals a listing.

For example, if a child were able to attend school in a regular classroom setting and is described as an average student and was participating in physical education and the evidence does not document any restrictions placed on the claimant's ability to function by any treating or examining physician of record, in terms of the six domains of function the ALJ would probably find the limitations caused by the claimant's impairments to be minimal.

### 81.a. What is the first of the six "functional domains"?

The first domain is "Acquiring and using information." This domain considers how well a child is able to acquire or learn information and use the information he/she has learned (20 CFR 416.926a(g)).

The regulations provide that a preschooler (i.e., a child age 3 to attainment of age 6) without an impairment should begin to learn and use the skills that will help him/her to read and write and do arithmetic when he/she is older. For example, listening to stories, rhyming words, and matching letters are skills needed for learning to read. Counting, sorting shapes, and building with blocks are skills needed to learn math. Painting, coloring, copying shapes, and using scissors are some of the skills needed in learning to write. Using words to ask questions, give answers, follow directions, describe things, explain what he/she means, and tell stories allows the child to acquire and share knowledge and experience of the world around him/her. All of these are called "readiness skills" and the child should have them by the time he/she beings first grade (20 CFR 416.926a(g)(2)(iii)).

The regulations provide that a school-age child (i.e., a child age 6 to the attainment of age 12) without an impairment should be able to learn to read, write, and do math, and discuss history and science. The child will need to use these skills in academic situations to demonstrate what he/she has learned by reading about various subjects and producing oral and written projects, solving mathematical problems, taking achievement tests, doing group work, and entering into class discussions. The child will also need to use these skills in daily living situations at home and in the community (e.g., reading street signs, telling times, and making change). The child should be able to use increasingly complex language (vocabulary and grammar) to share information and ideas with individuals or groups, by asking questions and expressing his/her own ideas, and by understanding and responding to the opinions of others (20 CFR 416.926a(g)(2)(iv)).

Social Security regulation 20 CFR 416.926a(g)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in acquiring and using information are: (i) does not understand words about space, size, or time (e.g., in/under, big/little, morning/night); (ii) cannot rhyme words or the sounds in words; (iii) has difficulty recalling important things learned in school yesterday; (iv) has difficulty solving mathematics questions or computing arithmetic answers; or (v) talks only in short, simple sentences, and has difficulty explaining what he/she means.

If the claimant has no limitation in acquiring and using information, the claimant would normally be in a regular classroom setting with no difficulty shown.

**81.b. What is the second of the six "functional domains"?**

The second domain is "Attending and completing tasks." This domain considers how well a child is able to focus and maintain attention, and how well she is able to begin, carry through, and finish activities, including the pace at which she performs activities and the ease of changing activities (20 CFR 416.926a(h)).

The regulations provide that a preschooler without an impairment should be able to pay attention when she is spoken to directly, sustain attention to her play and learning activities, and concentrate on activities like putting puzzles together or completing art projects. The child should also be able to focus long enough to do many more things independently, such as gathering clothes and dressing, feeding, or putting away toys. The child should usually be able to wait her turn and to change her activity when a caregiver or teacher says it is time to do something else (20 CFR 416.926a(h)(2)(iii)).

The regulations provide that a school-age child without an impairment should be able to focus her attention in a variety of situations in order to follow directions, remember and organize school materials, and complete classroom and homework assignments. The child should be able to concentrate on details and not make careless mistakes in her work (beyond what would be expected in other children of the same age who do not have impairments). The child should be able to change activities or routines without distraction, and stay on task and in place when appropriate. The child should be able to sustain attention well enough to participate in group sports, read by herself, and complete family chores. The child should also be able to complete a transition task (e.g., be ready for the school bus, change clothes after gym, change classrooms) without extra reminders and accommodation (20 CFR 416.926a(h)(2)(iv)).

Social Security regulation 20 CFR 416.926a(h)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in attending and completing tasks are: (i) is easily startled, distracted, or over-reactive to sounds, sights, movements, or touch; (ii) is slow to focus on, or fails to complete, activities of interest (e.g., games or art projects); (iii) repeatedly becomes side-tracked from activities or frequently interrupts others; (iv) is easily frustrated and gives up on tasks, including ones she is capable of completing; or (v) requires extra supervision to remain engaged in an activity.

If the claimant has no limitation in attending and completing tasks, the evidence of record would not show any evidence of deficit.

### 81.c. What is the third of the six "Functional Domains"?

The third domain is "Interacting and relating with others". This domain considers how well a child is able to initiate and sustain emotional connections with others, develop and use the language of the community, cooperate with others, comply with rules, respond to criticism, and respect and take care of the possessions of others (20 CFR 416.926a(i)).

The regulations provide that a preschooler without an impairment should be able to socialize with children as well as adults. The child should begin to prefer playmates and start developing friendships with children who are her own age. The child should be able to use words instead of actions to express herself, and also be better able to share, show affection, and offer to help. The child should be able to relate to caregivers with increasing independence, choose her own friends, and play cooperatively with other children, one-at-a-time or in a group, without continual adult supervision. The child should be able to initiate and participate in conversations, using increasingly complex vocabulary and grammar, and speaking clearly enough that both familiar and unfamiliar listeners can understand what she says most of the time (20CFR 416.926a(i)(2)(iii)).

The regulations provide that a school-age child without an impairment should be developing more lasting friendships with children who are of the same age. The child should begin to understand how to work in groups to create projects and solve problems. The child should have an increasing ability to understand another's point of view and to tolerate differences. The child should be well able to talk to people of all ages, to share ideas, tell stories, and to speak in a manner that both familiar and unfamiliar listeners can readily understand (20 CFR 416.926a(i)(2)(iv)).

Social Security regulation 20 CFR 416.926a(i)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty that children could have in interacting and relating with others are: (i) does not reach out to picked up and held by a caregiver; (ii) has no close friends or all friends are older or younger than the child; (iii) avoids or withdraws from people he knows, or is overly anxious or fearful of meeting new people; (iv) has difficulty playing games or sports with rules; (v) has difficulty communicating with others (e.g., in using verbal and nonverbal skills to express herself, in carrying on a conversation, or in asking others for assistance); or (vi) has difficulty speaking intelligibly or with adequate fluency.

A claimant would have no limitation in interacting and relating with others if the evidence does not show any allegation of or objective evidence of any speech or communication disorder.

### 81.d. What is the fourth of the six "Functional Domains"?

The fourth domain is "Moving about and manipulating objects". This domain considers how well a child is able to move her body from one place to another and how a child moves and manipulates objects. These are called gross and fine motor skills (20 CFR 416.926a(j)).

The regulations provide that a preschooler without an impairment should be able to walk and run with ease. The child's gross motor skills should let her climb stairs and playground equipment with little supervision, and let her play more independently (e.g., swing by herself and possibly start learning to ride a tricycle). The child's fine motor skills should also be developing. The child should be able to complete puzzles easily, string beads, and build with an assortment of blocks. The child should be showing increasing control of crayons, markers, and small pieces in board games, and should be able to cut with scissors independently and manipulate buttons and other fasteners (20 CFR 416.926a(j)(2)(iii)).

The regulations provide that a school-age child without an impairment should have gross motor skills that let her move at an efficient pace at school, home, and throughout the neighborhood. The child's increasing strength and coordination should expand her ability to enjoy a variety of physical activities, such as running and jumping, and throwing, kicking, catching, and hitting balls in informal play or organized sports. The child's development of fine motor skills should enable her to do things like use many kitchen and household tools independently, use scissors, and write (20 CFR 416.926a(j)(2)(iv)).

Social Security regulation 20 CFR 416.926a(j)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in moving about and manipulating objects are: (i) difficulty with motor activities (e.g., stumbling, unintentionally dropping things) because of muscle weakness, joint stiffness, or sensory loss (e.g., spasticity, hypotonia, neuropathy, or paresthesia); (ii) difficulty with balance or climbing up and down stairs, or jerky or disorganized locomotion; (iii) difficulty coordinating gross motor movements (e.g., bending, kneeling, crawling, running, jumping rope, or riding a bike); (iv) difficulty with sequencing hand or finger movements; (v) difficulty with fine motor movement (e.g., gripping or grasping objects); or (vi) poor eye-hand coordination when using a pencil or scissors.

A claimant has no limitation in moving about and manipulating objects if the examination of the claimant had not shown any neurological or orthopedic deficits, or that a claimant participates in physical education at school and physical education was one of her favorite classes.

### 81.e. What is the fifth of the six "Functional Domains"?

The fifth domain is "caring for yourself". This domain considers how well a child maintains a healthy emotional and physical state, including how well a child satisfies her physical and emotional wants and needs in appropriate ways. This includes how the

child copes with stress and changes in the environment and whether the child takes care of her own health, possessions, and living area (20 CFR 416.926a(k)).

The regulations provide that a preschooler without an impairment should want to take care of many of her own physical needs (e.g., putting on shoes, getting a snack), and also want to try doing some things that she cannot do fully (e.g., tying shoes, climbing on a chair to reach something up high, taking a bath). Early in this age range, it may be easy for the child to agree to do what her caregiver asks. Later, that may be difficult for the child because she wants to do things her way or not at all. These changes usually mean that the child is more confident about her ideas and what she is able to do. The child should also being to understand how to control behaviors that are not good for herself (e.g., crossing the street without an adult) (20 CFR 416.926a(k)(2)(iii)).

The regulations provide that a school-age child without an impairment should be independent in most day-to-day activities (e.g., dressing and bathing), although she may still need to be reminded sometimes to do these routinely. The child should begin to recognize that she is competent in doing some activities but has difficulty doing others. The child should be able to identify those circumstances when she feels good about herself and when she feels bad. The child should begin to develop understand of what is right and wrong, and what is acceptable and unacceptable behavior. The child should also begin to demonstrate consistent control over her behavior, and be able to avoid behaviors that are unsafe or otherwise not good for her. At this age, the child should begin imitating more of the behavior of adults she knows (20 CFR 416.926a(k)(2)(iv)).

Social Security regulation 20 CFR 416.926a(k)(3) sets forth some examples of limited functioning in this domain that children of different ages might have. The examples do not apply to a child of a particular age; rather, they cover a range of ages and developmental periods. In addition, the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have in caring for themselves are: 9i) continues to place non-nutritive or inedible objects in the mouth; (ii) often uses self-soothing activities that are developmentally regressive (e.g., thumb-sucking or re-chewing food); (iii) does not dress or bathe age-appropriately; (iv) engages in self-injurious behavior (e.g., suicidal thoughts or actions, self-inflicted injury, or refusal to take medication), or ignores safety rules; (v) does not spontaneously pursue enjoyable activities or interests; or (vi) has disturbances in eating or sleeping patterns.

A claimant would have no limitation in the ability to care for herself if no problems were alleged in this area and no deficits were observed by any treating sources.

### 81.f. What is the last of the six "Functional Domains"?

The sixth domain is "health and physical well-being". This domain considers the cumulative physical effects of physical and mental impairments and any associated

treatments or therapies on a child's functioning that were not considered in the evaluation of the child's ability to move about and manipulate objects (20 CFR 416.929a(l)).

Social Security regulation 20 CFR416.926a(l)(3) sets forth some examples of limited functioning in this domain that children of any age might have; however the examples do not necessarily describe "marked" or "extreme" limitation in the domain. Some examples of difficulty children could have involving their health and physical well-being are: (i) generalized symptoms, such as weakness, dizziness, agitation (e.g., excitability), lethargy (e.g., fatigue or loss of energy or stamina), or psychomotor retardation because of any impairment(s); (ii) somatic complaints related to an impairment (e.g., seizure or convulsive activity, headaches, incontinence, recurrent infections, allergies, changes in weight or eating habits, stomach discomfort, nausea, headaches or insomnia); (iii) limitations in physical functioning because of treatment (e.g., chemotherapy, multiple surgeries, chelation, pulmonary cleansing, or nebulizer treatments); (iv) exacerbations from an impairment(s) that interfere with physical functioning; or (v) medical fragility requiring intensive medical care to maintain level of health and physical well-being. If a claimant has no marked limitation in health and physical well-being, she does not fulfill the domain criteria.

**81.g. If a child has only one "marked" limitation and no "severe" ones, can she be found to be disabled?**

No. The requirement of severity is not met by equaling or surpassing only one "severe" limitation. Accordingly, if a claimant does not have any impairment or combination of impairments that result in either "marked" limitations in two domains of functioning or "extreme" limitation in one domain of functioning.

**81.h. When does a claimant become eligible for Medicaid or Medicare if he or she is disabled?**

In Florida, an SSDI or SSI awardee/recipient will first be entitled to Medicaid benefits for the first two years of disability; thereafter, he or she will be covered by Medicare. For example, John Q. Public was born on 09/11/53 and files his disability claim, (SSDI or SSI) on February 1, 2007. He alleges he was disabled when he had back surgery on February 1, 2006. He treats with Dr. Jones throughout this entire time. On September 19, 2009 Judge Hemshearth renders an opinion that Mr. Public was disabled as alleged on February 1, 2006. Mr. Public's bills are reimbursable to Mr. Public through Medicaid, a State run program, between February 1, 2006 and February 1, 2008. Thereafter, they are payable or reimbursable through Medicaid, a federally run program. The only exception to the running of this rule would be if Mr. Public reached his full retirement age between February 1, 2006 and February 1, 2008, whereupon he would qualify for Medicare, (usually age 65-67, depending where in the Baby Boom he is) prior to February 1, 2008.

**81.i. In Florida, if a person is disabled and a Medicare recipient, can a physician legally charge him or her more than Medicare will allow?**

No. Florida Statute §456.056, Treatment of Medicare Beneficiaries, provides in pertinent part of the following:

(5) Any attempt by a primary physician or a consulting physician to collect from a Medicare Beneficiary any amount of charges for medical services in excess of those authorized under this Section, other than the unmet deductible and the 20 percent of charges that Medicare does not pay, shall be deemed null, void, and of no merit.

**81.j. How can a physician go about legally charging more than Medicare will pay?**

If a physician seeks to have a Medicare Beneficiary held liable as an individual for charges that are in excess of the Medicare-Approved Amounts, the physician must meet the requirements of 42 U.S.C. §1395a that mandates a written contract between the physician and the Medicare Beneficiary must be entered into and signed by both individuals, that the contract set forth the specific services to be provided, that the Medicare Beneficiary will not submit a claim to Medicare, that the Medicare Beneficiary understands he or she will be responsible for payment of services and that Medicare will not reimburse him or her for those services, that the Medicare Beneficiary acknowledges there exists limits under Medicare regulations limiting charges to specific amounts, that the Medicare Beneficiary has the right to services provided by other physicians who would limit their charges to Medicare-Approved Amounts, and that the physician indicate whether or not he or she is a participant in the Medicare program. If no contracts that meet these requirements exist, then your physician may not collect more then the Medicare allotted amounts.

In addition to the contractual requirements, the physician must notify Medicare by way of affidavit stating that the physician will not submit a claim under Medicare for services provided to the Medicare Beneficiary for at least two years after executing the contract. If the physician fails to abide by the regulations and codes under 42 U.S.C. § 1395 et seq, the physician may be subject to sanctions including fines amounting to two to three times the excessive charge, removal from the Medicare program, refunding of any payments made by the beneficiary that are excessive and assessment of $2,000.00 for each instance of excessive billing.

It is obvious that Medicare does not want Medicare Beneficiaries to be taken advantage of by physicians circumventing the Beneficiaries right to have the charges limited by Medicare.

# FLORIDA LAW

**82. So, if a disabled person is in an accident in Florida, what should the physician do?**

An injured recipient of Medicare who is in an accident, particularly a motor vehicle accident, may have only a limited amount of PIP benefits, so in writing, a Medicare recipient should have already advised his physician of or that PIP benefits are exhausted. At this time the physician should bill Medicare for their services after PIP benefits run out; otherwise, you may be forced into litigation over your bills.

**83. Does Florida law define me as a Medicare recipient?**

Florida Statute §456.056 defines "Beneficiary" as a "beneficiary of health insurance under Title XVIII of the federal Social Security Act." (42 U.S.C. § 1395 at seq., Health Insurance for Aged and Disabled).

**84. If a Florida Medicare recipient becomes an injured party, and is a Medicare Beneficiary, who is liable for damages including the amounts that treating physicians charged under contract/letters of protection?**

The patient is liable to his physicians for bills he incurs even though the person who caused you injury may be liable to him to compensate him for those damages. If a patient assigns his claim in writing to a physician, that physician now has claim for the bills the patient incurred to the physician on account of someone else's negligence but this recovery is a limited one.

1. Pursuant to Florida Statute §465.056 treating physicians are limited to charges authorized by Medicare as found in 42 U.S.C § 1395 et seq., which provides that physicians may charge only a limited amount above the Medicare-Approved Amount when the physician does not accept assignment of the claim. See 42 U.S.C. § 1395w-4 et seq., 42 C.F.R. §§ 424.56 and 414.48.

2. Medicare set the limiting charges for years subsequent to 1993 at 115% of the Medicare-Approved amount for unassigned claims. See 42 C.F.R §414.20 and 42 C.F.R. §414.48 (if the physician accepts assignment of the claim, the physician is limited to only 100 percent of the Medicare-Approved Amount.)

3. Moreover pursuant to 42 U.S.C.A § 1395w-4 (g) no Medicare Beneficiary is liable for payments of any amounts billed for service in excess of the limiting charge.

4. Physicians who are enrolled with Medicare are bound by agreements not to charge Medicare Beneficiaries individually for services that the individual could have had covered under Medicare. See 42 U.S.C. §1395cc. So, upon injury by another party, a Medicare recipient should notify his/her physician immediately that he/she is a Medicare recipient so that neither the physician nor the patient is stuck holding the bag for medical services or expecting the patient or the at-fault party to make payments that Medicare would otherwise make.

**85. So, how would this work out in an accident case involving A Medicare beneficiary?**

For example, in an accident case, it is not unusual for physicians to bill the injured patient in excess of Medicare paid services, because there is a financial incentive to do so. The American Orthopedic Institute billed $35,417.47 over the limiting charges allowed by Medicare for the arthroscopic surgery for knee meniscus tear and related services. Dr. Smith billed $779.44 over the limiting charges allowed by Medicare for a single office visit and Calcium Chiropractic and Rehab billed $2481.28 over the limiting charges allowed by Medicare for chiropractic care and services. Billing amounts for these physicians exceed $46,018.35, which exceeds the Medicare-Approved amounts by at the least $40,000.00. The actual Medicare-Approved amounts equate to only about $7,440.00 for these services. Wow!

**86. How do courts limit these recoveries from physicians in Florida?**

The Second District Court of Appeal addressed the admissibility of charges exceeding Medicare amounts in Cooperative Leasing Inc. and Domer v. Johnson, 872 So.2d 956, (Flat 2d DCA 2004). The facts in Cooperative were that a motorist was injured in an automobile accident and the trial court allowed into evidence bills for all medical expenses. The bills were in excess of benefits paid by Medicare. The Second DCA ruled that the excessive billing was inadmissible because the plaintiff was not liable for the excessive billing pursuant to Title 42 U.S.C. §1395 and precedent. In citing the U.S.C., the Second District determined that the plaintiff's medical bills were paid by Medicare at the Medicare-approved amounts and that the physician could not recover from the plaintiff personally. The Second District goes on to provide precedent that the plaintiff is entitled to compensation for reasonably valued medical care and found that the Medicare amounts paid to the physicians were customary and reasonable. This is also the basis for approved amounts under 42 U.S.C. §1395w-4. Therefore, any amounts in excess of the Medicare-approved amounts would allow the plaintiff to receive a windfall by recovering "phantom damages." Id, at 959. In its ruling, the Second District goes on to provide that the difference between what the physicians charged and the Medicare-Approved Amounts are not a collateral source that would be deducted as a set-off post verdict. Id. At 960.

Moreover, all billing of the above physicians that do not meet the requirements for contracting with a Medicare Beneficiary and/or that are in excess of the Medicare-Approved Amounts are null, void, and of no merit as a matter of law pursuant to Florida Statute §456.056 It is of the utmost importance, therefore that if a Medicare recipient is involved in any accident that he let his treating physician know he is disabled and on Medicare, so that he/she does not create any outstanding bills or bad-will by failing to tell you the physician up front to bill Medicare.

# RESIDUAL FUNCTIONAL CAPACITY FORMS LIST

In the Appendix you will find the appropriate Residual Functional Capacity Forms.

Abnormal Curvatures of the Spine
Arthritis
Bladder Problem

Cardiac
Cervical Spine
Childhood Disability Evaluation
Chronic
Chron's Colitis IBS
Diabetes Mellitus
Disorders of the Spine
Dizziness
Fibromyalgia
Headaches
Hearing Impairment
Hepatitis C
Interstitial Cystitis
Lumbar Spine
Lupus (SLE)
Mental Impairments
Multiple Sclerosis
Neuropathy
Obesity
Parkinsons
Physical
Postpolio Sequlae
Seizures
Sleep Disorders
Spinal Arachnoiditis & Questionnaire
Spinal Nerve Stroke
Vision Impairment

# PRIVATE LONG TERM DISABILITY CASES: F.A.Q.S.

**1. If I am receiving Long Term Disability Insurance Benefits from an insurer, how will Social Security disability benefits affect my Long Term Disability benefits?**

If you are approved for Social Security disability benefits, your disability payments from your Long Term Disability Insurer probably will be reduced by the amount you and any dependents receive under Social Security. In other words, you will continue to receive the same total amount of monthly benefits, but the money will come from two sources.

Typically you will receive a large retroactive payment from Social Security shortly after your claim is approved. Your Long Term Disability insurer considers this money essentially to be money that the Long Term Disability insurer advanced to you while you were awaiting Social Security's decision. Usually you must pay it back to the Long Term Disability insurer immediately after you receive it from the Social Security Administration.

While your disability benefits from the Long Term Disability carrier probably will be reduced once you are awarded SSDI, the Social Security Cost of Living increases will be yours to keep. Over time, the value of those increases can be significant. For example, an individual earning $50,000.00 a year who became disabled at age 40 and remained disabled until retirement would receive over $238,000 in additional benefits. Ultimately, Social Security cost of living adjustment adds money to your pocket each year.

**2. If I am receiving Long Term Disability benefits, how do I apply for Social Security benefits?**

Go to the following websites and click on:
Social Security Online: www.ssa.gov
Office of Employment Support Programs - Information about work incentive programs: www.ssa.gov/work
Office of Disability - Comprehensive information about Social Security disability benefits programs: www.ssa.gov/disability/3368/

**3. If I have been found to be disabled by my Long Term Disability Carrier, what are my chances of receiving Social Security benefits?**

Your chances are excellent. More than 90 % of individuals receiving long term disability (LTD) benefits from some long term disability insurers are eventually awarded Social Security disability benefits. However, Social Security initially denies more than 60 percent of the applications it receives. But, it pays to be persistent - most of those applicants are awarded benefits through the appeals process.

Here's how it works:

1. Your initial application for benefits will be reviewed within three to four months.

2. If your application is denied, you may request a Reconsideration. This is a review by a different person at the Social Security Administration and it generally takes less than two months.
3. If Social Security continues to deny your claim, you can appeal to an Administrative Law Judge. Don't be intimidated by this prospect. Nearly 60 % of claimants who take this step are awarded benefits.
4. Plus, you have 60 days to appeal any decisions, so do not wait.

**4. Should I send Social Security a copy of the LTD Carrier's medical evaluation and my treating physician's monthly disability statements?**

Yes. These documents will show that you were at least unable to engage in your prior occupation, which is part of the battle in getting your social Security Disability benefits.

**5. Do I need to hire a lawyer to help me through the LTD application process?**

Beware if your long term disability case manager believes legal assistance is necessary. Even though your long term disability carrier may provide it, and may claim to pay for it, in general, we recommend retaining an attorney, especially if your case will be heard by an Administrative Law Judge. You should not hire anyone but an attorney who is a member of the Federal Bar and is certified by a United States Court of Appeals and the United States Supreme Court so that attorney can represent your interests all the way. Qualified attorneys are very reluctant to take on cases other attorneys or representatives have handled because of the Federal fee cap and having a share or split limited fees with unsuccessful or unqualified representatives or attorneys.

**5.a. Whom should I contact if I am disabled and have been a Florida county or state employee?**

You should contact:
Florida Retirement System Pension Plan
Application for Disability Retirement
2639 N. Monroe St., Bldg. C
Tallahassee, FL 32399-1560

or your Human Resources and Benefits coordinator at your place of government employment.

**5.b. What will I need to file?**

The Florida Retirement System (FRS) provides two types of disability retirement benefits: "in-line-of-duty" and "regular." "In the line of duty" refers to being disabled by a condition or illness that was related to your work as a state employee. "Regular" refers to all other cases.

To apply for disability retirement, you must complete and submit the following forms:

FORM FR-13, Application for Disability Retirement- You must provide the Division of Retirement with a properly-signed and completed disability application FORM Fr-13. Your retirement date is determined by the date the Division received your disability application. Therefore, you may submit your application prior to submitting the other required forms. Your retirement date will be established as follows:

If you are no longer employed and your disability application is not received within thirty days of your termination date, your effective retirement date will be the first day of the month following the date we receive your application.

If your disability application is received within thirty days of your termination date, your effective retirement date will be the first day of the month following your termination date.

If you are currently employed in an FRS-covered position, your effective retirement date will be the first day of the month following the date we receive your disability application or the first day of the month following the last month for which salary is reported or creditable service is granted, provided we receive your disability application before such day and your documented termination date occurs after such day. Your effective retirement date cannot be established until you have officially terminated all FRS-covered employment and all required documents have been received.

FORM FR-13a, Statement of Disability by Employer- This form must be completed and signed by an appropriate agency official in your Personal Office or your immediate supervisor.

FORM FR-13b, Physician's Report- As proof of disability, Statute 121.091(4) requires two different Florida-licensed physicians who have treated you for your disabling condition to attest to your total and permanent disability. It may be advisable to consult an attorney who handles State Retirement and Disability Retirement before doing so, as choosing the wrong doctor will hurt your case.

## "COBRA" COVERAGE F.A.Q.S.

**1. What is "Cobra" Coverage?**

COBRA, the Consolidated Omibus Budget Reconsciliation Act, is part of ERISA, the Employee Retirement Security Act, as amended. This act generally applies to companies with 20 or more employees in a prior year and provides for the continuation of group health coverage in situations where such coverage would be terminated.

**2. If I am employed and get health insurance coverage through my employer and it stops, what is continuation coverage?**

Federal law requires that most group health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, and the covered employee's spouse and dependent children.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

**3. How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours or employment, coverage generally may be continued up to a total of 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation, the employee's Medicare entitlement, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying even, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

**4. When will continuation coverage will be terminated before the end of the maximum period?**

- if any required premium is not paid on time.
- if a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary.
- if a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage.
- if the employer ceases to provide any group health plan for its employees, and
- for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

**5. How can you extend the length of continuation coverage? (If your maximum less than 33 months).**

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying even occurs. You must notify your benefits coordinator of disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

**6. Will applying or receiving Social Security Disability affect my COBRA coverage?**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation of coverage. You must make sure that your benefits coordinator is notified of the SSA's determination (Award letter) within 60 days of the date of determination and before the end of the 18-month period of COBRA continuation coverage n order to extend your coverage. If this notice is not received by your benefits coordinator on time, the extension will not be processed. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify your benefits coordinator of that fact within 30 days after the SSA's determination.

**7. What is a "Second Qualifying Event"?**

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage

available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's Medicare entitlement (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify your benefits coordinator within 60 days after a second qualifying even occurs if you want to extend your continuation coverage.

**8. How can I elect continuation coverage?**

To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you would take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more that a 63-day gap in health coverage. Election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have a right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event previously listed. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**9. How much does continuation coverage cost?**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation period for each option is described on the page titled "Applicable Coverage/Rates."

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-fee at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002actindex.asp.

**10. When and how must payment for COBRA continuation coverage be made?**

First payment for continuation coverage. If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later those 45 days after the date of your election (the date the Election Notice is post-marked). Your first payment should cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact your benefits coordinator to confirm the correct amount of your first payment. If you do not make your first payment for continuation coverage in full no later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

PLEASE NOTE: Continuation coverage will not be reinstated until the completed Election Form(s) AND first payment are received and processed by your benefits coordinator. A returned check fee will be charged for checks returned for non-sufficient funds.

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The current amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments are to be made on a monthly basis. Payment is due on the first day of each coverage month. Monthly invoices are normally sent between the 15th - 20th prior to the coverage month. However, you are still responsible for mailing your payment should you not receive an invoice due to postal delays or mishandling. Coverage will normally be terminated if payment is not received timely. Not receiving an invoice will not be accepted as a reason for late- or non-payment. Coverage will not be reinstated.

**11. Are there any grace periods for periodic payments?**

Although periodic payments are due on the date shown above, you will be given a grace period through the last day of the coverage month to make each periodic payment. Your continuation coverage should be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan. All payments should be paid to your benefit coordinators, attention COBRA, at the appropriate address.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

**12. Is there more information available on continuation coverage or other rights I may have?**

More information about continuation coverage and your rights under the plan is available in your summary plan description or from the plan administrators. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact your benefits coordinator in writing.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.doi.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website.

**13. Do I need to keep my plan administrator?**

Yes. In order to protect your family's rights, you should keep your benefits coordinator informed of any changes in your address and the addresses of family members. If you elect continuation coverage, you are directly responsible for notifying your benefits coordinator in writing of divorce, legal separation, or a child losing dependent status within 60 days after the qualifying event occurs. Also, when you experience a qualifying event such as birth or adoption of a child, or marriage, you must notify the benefits coordinator in writing within 30 days after the qualifying event occurs. You must send this notice in writing to the benefits coordinator. Failure to do so will result in the spouse/child not being added to the coverage. You should include the name, address, daytime telephone number, Social Security number, and/or Participant ID, explain the

type of qualifying event and the qualifying event date. You should also keep a copy, for your records, of any communications you sent to us.

**14. Will I receive notice of my right to continue my health care coverage after employment is terminated?**

Yes. Your notice contains important information about your right to continue your health care coverage in your employer's group health plan. You must affirmatively elect COBRA continuation coverage.

If you do not elect COBRA continuation coverage, your coverage under the plan will generally end on the date your employment was terminated. Each person (qualified beneficiary) listed in your notice may be entitled to elect COBRA continuation coverage, which will coverage group health care coverage under the plan for up to 18 months. If elected, COBRA coverage will begin on the date you left your employment and can last until 18 months thereafter.

You normally do not have to send any payment with the election form. However, coverage will not be reinstated until the completed election form and premiums due are received and processed by the office designated in your notice. This process may take 7 - 10 days in some cases. Any claim(s) submitted for benefits may be denied and may have to be resubmitted once all premiums due have been paid and your coverage is reinstated. Important additional information about payment for COBRA continuation coverage should be available from your employer or benefits coordinator.

**15. What will my election form look like and what will it require of me?**

To elect COBRA continuation coverage, an employee will complete an election form and any applicable carrier forms and return it to the employer's benefits coordinator. Under federal law, you must have 60 days after the date of this notice to decide if you want to elect COBRA continuation coverage under the plan.

Your election form and carrier forms must be completed and returned by mail. It must be postmarked no later than 60 days after your termination of employment. Normally, one makes checks payable to the benefits coordinator and should include the participant's SSN/Part, ID on the check.

If you do not submit a completed election form by the due date required, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed election form.

Normally, your election form will appear like the following example:

I (we) elect COBRA continuation coverage in the plan as indicated below:

| Qualified Beneficiary Name | Date Of Birth | Sex | Relationship to Employee | SSN/Part ID |
|---|---|---|---|---|
| a. _____ | _____ | _____ | _____ | _____ |
| b. _____ | _____ | _____ | _____ | _____ |
| c. _____ | _____ | _____ | _____ | _____ |
| d. _____ | _____ | _____ | _____ | _____ |

Refer to the "Applicable Coverage/Rates" page to list below the benefits that you wish to elect under COBRA.

| Coverage | Plan | Enrollment Level | Monthly Rate |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

COVERAGE WILL NOT BE REINSTATED UNTIL THE COMPLETED FORM(S) AND INITIAL PAYMENT IS RECEIVED AND PROCESSED BY THE APPROPRIATE OFFICE.

To calculate the amount of your first check:

Month check is mailed: Months you owe for: Multiply monthly rate above by:

# FREQUENTLY ASKED QUESTIONS, FLORIDA WORKERS' COMPENSATION DISABILITY

The following is a section dealing exclusively with Florida's Workers Compensation Law. If you are not insured under Florida's Workers Compensation Law and are insured by a Federal or other State Workers Compensation Act, this website does not purport to give legal opinions on any law other than Florida's Workers Compensation Law.

**1. What is the purpose of Workers' Compensation?**

The purpose of Workers' Compensation is to assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker's return to gainful employment at a reasonable cost to the employer. It is supposed to be a self-executing system, but it is often not. It is also a system in which the laws are supposed to be construed not liberally in favor of either employee or employer, but it is often not. Note: nowhere does the law emphasize that it is there to actually help the worker have a better life.

**2. What is an "accident" within the meaning of Florida's Workers Compensation Law?**

An "accident" means only an unexpected or unusual event or result that happens suddenly. However, only acceleration of a condition or death or acceleration or aggravation of a pre-existing condition that is reasonably attributable to the accident is comprehensible. Exposure to toxic substances, for example, does not constitute an "accident" unless there is clear and convincing evidence establishing that exposure to the specific substance involved.

**3. Whom is covered by Florida's Workers Compensation Act?**

"Employees" are covered under Florida's Workers Compensation Act, including people who work for wages or salaries in the state or for a Florida employer and officers of corporations who have not opted out of the system within narrowly-drawn parameters. It also includes sole proprietors, partners, and all persons being paid by a construction contractor or subcontractor unless otherwise exempted. It includes independent contractors, sole proprietors, employees, and paid agents.

**4. What if I get injured and my boss doesn't have Workers' Compensation coverage?**

Every employer who fails to secure the payment of compensation as provided by Florida's Workers' Compensation Act may not in any suit brought against him by an employee for damages defend the suit on the grounds that the injury was caused by the negligence of the fellow worker or employee or that the injured worker assumed the risk in his employment and/or was comparatively negligent. The Florida Workers' Compensation Act insulates an employer against suit for monetary damages under most circumstances where the employer is covered by Workers' Compensation insurance.

**5. My doctor has told me that I will be at "maximum medical improvement" (or "MMI") soon. What does that mean?**

The date of the your maximum medical improvement, or MMI, means the date after which further recovery or lasting improvement to an injury or disease can no longer reasonably be anticipated based on reasonable medical probability. Your date of MMI has to include both physical and mental (if any) dates should there be a relationship to either or both to the industrial accident.

**6. I have heard that my doctor says that my injury was not the major contributing cause of my problems. What is "major contributing cause" mean?**

"Major contributing cause" is a cause that more so than any other cause has created the resulting physical condition that the employee suffers from. If an injury arises out of the course of employment and combines with a pre-existing condition or cause or prolonged disability or need for treatment, the employer is responsible to pay compensation or benefits required only to the extent that the injury arising out of course of employment remains more than 50% responsible for the injuries as compared to all other causes combined and thereafter remains the major contributing cause of the disability and need for treatment. "Major contributing cause" must be demonstrated by medical evidence only. In short, it is the single cause that contributes to the injury or disability more than all other causes combined.

**7. When is compensation payable for my lost wages and medical bills?**

Compensation is payable when a person is injured on the job or within certain limitations in going and coming. It also includes traffic accidents that occur while the Claimant is within the scope of his employment. Compensation is not payable if the injury was occasioned primarily by the intoxication of the employee or by drugs and habituates or

other stimulants not prescribed by a physician. The willful intentional act of an employee to injure/kill himself or herself or another is also not included as compensable.

**8. What if I am injured in a motor vehicle accident while I'm on the job? What can I do?**

Traveling employees are covered under the Florida Workers' Compensation Act in most situations. An employee who is required to travel in connection with his/her employment who suffers an injury while in travel status is eligible for benefits under the Florida Workers Compensation Act if the injury arises out of course of employment while the employee was actively engaged in the duties of employment. The Florida Workers Compensation Act applies to travel necessarily incident to performance of the employee's job responsibilities but does not include travel to and from work unless there are specific circumstances, like being paid while traveling or while en-route to and from a job site or while traveling in an employer-owned vehicle.

**9. If I am in an accident while at work what do I do?**

The first thing you need to do is to notify your employer of the accident. The law requires the employee to do this and for the employer to notify the Workers' Compensation carrier with all due speed. Also do this in writing and ask to file a "Notice of Injury" and keep a copy for your records.

**10. What if I am injured and I fail to advise my employer of the injury within 30 days after the initial manifestation of the injury?**

You will lose your rights. Failure to advise the employer shall bar petition and/or payment of any benefits under the Florida Workers Compensation Act unless your employer or his/her agent had actual knowledge of the injury and the cause of the injury could not be identified without a medical opinion or the employee advised the employer within 30 days after obtaining a medical opinion that the injury rose out within the course of employment or the employer did not put the employees on notice of the requirements of the Workers' Compensation section by appropriate posting of coverage. There are some exceptional circumstances which are beyond the scope of this question so consult with us or another attorney who does Workers' Comp.

**11. What if I report my injury to my boss, and he does not report the injury to the Workers' Compensation carrier?**

You must contact your Workers' Comp carrier yourself. Your Workers' Compensation carrier could be fined. It is against the law not to report the injury.

**12. What if I'm in a motor vehicle accident? What insurance applies?**

If you are in a motor vehicle accident involving your work, the first thing you must do as soon as your can is report the accident to your employer. Different laws apply to different vehicles; however, Florida's Workers' Compensation Act provides for the primary insurance for the accident and your recovery, lost wages and care. Many attorneys who advertise themselves as "Personal Injury Attorneys" will miss this or may intentionally avoid the Workers' Comp issues because they do not understand them. We think this is wrong. It is important that if you're injured the in motor vehicle accident that one elects to have medical treatment under Florida's Workers Compensation Act since the amount of medical coverage is unlimited. Unlike the PIP/No Fault benefits, which max out at $10,000, your medical benefits for Workers' Compensation are potentially unlimited for you as an individual. Moreover, if the accident involves the negligence of another person, if you treat under Florida's Workers Compensation Act, you will not have to expend your PIP benefits which can be used to your own benefit in any settlement against the person who caused the accident since those PIP benefits can be used to pay off any Workers' Compensation lien that may exist in your case or be used by you at a later date for lost wages and medical care. More importantly, should you be treated under Florida's Workers' Compensation Act and be the victim of a medical negligence as a consequence of your treatment by an authorized Workers' Compensation treating physician, then your damages from that negligence (medical malpractice) is covered as well and as far as your lost wages and need for future medical care and treatment. If this happens under a letter of protection or by a doctor that's treating you that is being paid by health insurance or PIP/No Fault benefits, you could be out of luck when it comes to getting additional medical care and treatment paid for by an insurer or the second party tort fees who caused the negligent or medical malpractice.

**13. When does the Workers' Compensation carrier have to pay me for my lost work?**

According to the law, no compensation is allowed for the first 7 days of disability expect benefits provided in Chap 440.13. However, if the injury results in disability of more than 21 days, compensation shall be allowed from the commencement of the disability onward. Essentially, there is a 7 day elimination period that employee is self insured for until he/she is actually disabled for 21 days and then the 7 day elimination period is dropped and the injured employee paid for his/her lost wages owed during this time.

**14. How are my medical fees paid?**

Except for emergency care treatment, fees for medical services are payable only to a healthcare provider who is certified & authorized to render remedial treatment, care, and

attendance by your Workers' Compensation carrier under the Florida Workers Compensation Act. This is why it is necessary to contact your Workers' Compensation carrier and get all treatment other than emergency care pre-authorized. Workers' Compensation carriers pay for only authorized care and not for any unauthorized care other than emergency room visits.

### 15. What is a "Workers' Compensation Managed Care Arrangement"?

A Workers' Compensation Managed Care Arrangement is one that's used by Workers' Compensation carriers to administer their cases. If the managed care agency is not administering the case properly, one must file a complaint or grievance, meaning a written complaint which must be filed before an employee is able to file a petition for benefits. The managed care arrangement just adds another level of bureaucracy to the Workers' Compensation system and is essentially a very frustrating means through which an injured worker has to grovel to get adequate medical care from a recalcitrant Workers' Compensation carrier.

### 16. If I am injured, to what compensation am I entitled?

If, after you are at MMI and on account of your work related injury, you have the severity of injury and symptoms that cause a permanent disability which prevents you from ever going back to even sedentary work, you may be declared "permanently totally disabled." This declaration will entitle you to 66% of the average weekly wage that you normally would have been earning had you not been injured. An injured employee is presumed not to be permanently and totally disabled unless the employee establishes that the employee is physically not capable of engaging in at least sedentary (sit-down) employment within a 50 mile radius of the employee's residence. Permanent Total Disability also includes, among other things, severe paralysis and amputation of upper and lower extremities as well as brain injuries and closed-head conditions as well as total industrial blindness and third-degree burns on 25% or more of the body and 5% of the face. In these cases the employee is not presumed to be able to find sedentary work within a 50 mile radius. Permanent Total Disability (PTD) can be very difficult to get without the aid of a well-experienced attorney.

### 17. How long do permanent total disability benefits last?

Under the present Workers' Compensation Act, entitlement to such benefits ends when the employee reaches age 75 unless the employee is not eligible for Social Security benefits.

**18. What if I'm not permanently totally disabled, just temporarily disabled? To what benefits am I entitled?**

Under that circumstance you may be entitled to Temporary Total Disability, which is 2/3 of your average weekly wage paid while you are convalescing or unable to work at all. This period lasts up to 104 weeks. After 104 weeks the employee is placed at statutory maximum medical improvement and those benefits end. We advise that our clients apply for Social Security benefits within the first year of disability or immediately after their first job-related surgery.

**19. What if I am disabled for more than 104 weeks?**

That's a tough question. It may be that an injured employee who is undergoing surgery or rehabilitation to apply for Social Security benefits as soon as possible. The Social Security assistance takes about 2-3 years to have a claim processed and you may run out of Workers' Compensation benefits during that period of time.

**20. What if I am able to go back to work but I can't work as much as I had due to my injury?**

You may be eligible for Temporary Partial Disability (TPD), which is when an injured employee returns to work with restrictions resulting from the accident and is earning wages less than 80% of the pre-injury average. Compensation is to be paid equal to 80% of the difference between 80% of the employee's average weekly wage and the salary wages or other remuneration the employee is able to earn post-injury as compared weekly. Weekly temporary partial disability benefits may not exceed an amount equal to 66 2/3% of the employee's average weekly wage at the time of the accident.

**21. Am I entitled to Permanent Impairment Benefits if I am not Totally Disabled?**

An injured employee is entitled to Permanent Impairment Benefits but they don't add up to very much. Once an employee has reached maximum medical improvement and has an impairment rating which is a whole body impairment rating, the Workers' Compensation carrier is supposed to pay the employer Impairment Income Benefits for a period based on the impairment rating. The payments are separate and apart from Temporary Partial or Temporary and Permanent Total Disability. The ratings vary but the payments are based on the following:

- For each percentage point from 1-10%, 2 weeks of benefits are to be paid to the employee for each percentage point of impairment;

- For each percentage point from 11-15%, 3 weeks of benefits are paid for each percentage point of impairment;

- For each percentage point from 16%-20%, 4 weeks of benefits are to be paid for each percentage point of impairment;

- For each percentage point from 21% and higher, 6 weeks of benefits are to be paid. Again, these benefits are in addition to TTD and PTD benefits.

**22. Am I eligible for benefits under the Workers' Compensation Act if I receive benefits under unemployment compensation?**

Under Florida's Workers' Compensation Act, no compensation benefits are payable for any temporary total disability when an injured employee has received or is receiving unemployment compensation benefits.

**23. What if I get into a benefit dispute with my Workers' Compensation carrier? What do I do?**

If it's a managed care case, please refer to the managed care issues recited above. If it's not a managed care case or you have completed the managed care grievance process, an injured employee may file a petition for benefits by certified mail, by electronic means with the Office of Judge of Compensation claims. This petition must meet special requirements of specificity and contain an allegation that all grievance procedures were exhausted and that a good-faith allegation that the Claimant made a good-faith effort to resolve the dispute. So make sure all of your disputes are well-documented with your Workers' Compensation Carrier. Again, you also must a good-faith effort to resolve the dispute with the carrier before filing the petition. It's advisable that this be done in writing and by certified mail as well.

**24. If I file my own petition will I be liable for costs?**

Costs and proceedings brought without reasonable ground can be taxed against the claimant. An unwary litigant may also be taxed a reasonable attorney's fees by the judge if the proceeding is brought without legal grounds.

**25. If I hire an attorney can I expect not to have the other side to pay my attorney's fees?**

Many attorneys take on Workers' Compensation cases for various reasons. Normally an attorney will charge the statutory fee based on the settlement of your case. The statutory fee is 20% of the first $5,000 of the amount of the benefits secured, 15% of the next $5,000 of the amount of benefits secured, and 10% of the remaining benefits secured up to the first 10 years after the claim is filed, and 5% of benefits secured after 10 years. If a claimant and attorney agree to file a petition for benefits for a medical issue or a payment indemnity benefits, then if the attorney is successful, the Workers' Compensation carrier would be responsible for the payment of a reasonable attorney's fee to the claimant's attorney and bear reasonable cost incurred by the other attorney and claimant in the prosecution of the claim. This was not the law for a number of years until it was finally decided by the Florida Supreme Court. For 4-5 years, attorneys who made their livings litigating cases against insurance companies were precluded from making a living that way because of the unconscionable changes that Florida legislators were encouraged to make by their benefactors, the Florida Workers' Comp insurers. As a consequence the insurers, who were not controlled by bad faith statutes in the state of Florida concerning Workers' Compensation matters, low-balled and squeezed insured employees into settling their cases for far less than the case was worth because the injured employee could not find attorneys to represent them in these sorts of cases. Now with the opinion of the Florida Supreme Court on the matter, private attorneys can be paid for winning against an employer or its Workers' Compensation insurer, and the insurer must pay the attorneys' fee. An attorney can also make a fee from the claimant if the case is settled, but that fee must be according to statute and approved by a Workers' Compensation Judge.

**26. If I am in debt and I assign my claim to a creditor is it a valid assignment?**

Under Florida's Workers Compensation Act no assignment, release or commutation of compensation or benefits due or payable under the Chapter except as provided by Chapter 440 shall be valid and shall be exempt from all claims of creditors and levy execution and attachments or other remedy or recovery or collection of a debt and this exemption may not be waived. Bottom line, if you're on Workers' Compensation your creditor can't get at the payment until the injured employee actually does something with his or her check by way of deposit or alienating monies.

**27. If I file a petition do I have to go to mediation?**

Yes, mediation is mandatory. Mediation can be public or private. If the parties fail to come to an agreement at mediation then a pre-trial stipulation must be completed and filed with the court putting the court on notice that mediation has failed and the settlement has not occurred and all issues are ripe and ready to be heard by the court.

**28. If there was an impasse at mediation when will my hearing be concluded?**

Final hearing must be held and concluded within 90 days after mediation conference unless stipulated by the parties and agreed to by the judge.

**29. If I think that I am permanently totally disabled can a Judge adjudicate me as such without the employer and Workers' Compensation carrier being given the opportunity to assess me for the purpose of reemployment?**

A judge of Compensation Claims cannot adjudicate your case until you've been evaluated for reemployment by the employer/carrier.

**30. If I am involved in an automobile accident within the scope of my employment, what should I do and what laws govern?**

We at the Law Offices of Mike Murburg have handled these types of cases for over twenty-five years. Report the accident as quickly as possible to your employer. This must be done preferably by telephone first and thereafter in writing if necessary. You'll need to fill out a report of injury at your employer's when you can, once you're out of the hospital. You can treat under Florida's Workers Compensation Act and see a number of physicians who are reputable under the Act. Your attorney may have knowledge about who is reputable and who is not. If your injury is severe and/or if you have a disagreement with one of your healthcare providers, you may have the opportunity to use your PIP insurance for another evaluation and have that evaluation and doctor's testimony admissible under certain circumstances. If you have a permanent injury under the Florida Workers Compensation Act and the person that caused the injury has insurance you may want to hire a lawyer to handle both the Workers' Compensation issue and the personal injury action. These sorts of actions are somewhat complicated and an attorney who does both will be an asset to you. This is so because the attorney will have to settle the case with the bodily injury carrier and settle your Workers' Compensation lien held by your Workers' Compensation carrier and/or health insurance carrier. One must be careful to use the available automobile insurance policy's PIP/No Fault and medical payment benefits to pay off any Workers' Compensation liens.

If you are injured in your own vehicle or your employer's vehicle there may be an insured motorist benefits that are available to you as well. Under certain circumstances the Workers' Compensation lien or health insurance lien will not apply to uninsured/underinsured benefits. It is best to check with an attorney to find out if in fact the lien applies. The same is true with any healthcare liens which may be legal or equitable in nature.

If you are totally disabled and it is permanent, then you may need to file for Social Security Disability benefits. If you will be receiving Medicare benefits, it is important that you speak with your attorney about any Workers' Comp or Bodily Injury settlement

in excess of $250,000.00. Moreover, depending on whether you're entitled to Social Security Disability or Supplemental Security Income benefits under the Social Security Act, you may endanger your entitlement to Medicaid and/or Medicare by an improper or improperly weighted settlement or retention of proceeds in excess of certain amounts. Often these sorts of cases involve settlement with the "tortfeasor," the person that caused the accident and the uninsured motorist carrier and thereafter a settlement in lump sum with the Workers' Compensation carrier as the Claimant goes on to Social Security and qualifies for Medicare benefits. At the time of the settlement of the Workers' Compensation, a qualified Medicare Set-aside account will probably have to be established so that you will continue to be entitled to Medicare benefits throughout dependency of your disability up and through the time of your full retirement age. Additionally, as to the UM carrier, caution must be taken so as to preserve the rights of your insurer and obtain their consent to settle.

**31. Who can handle such a lawsuit or claims or a complicated settlement of an on-the-job accident or injury involving motor vehicles or product liability issues?**

Different statutes of limitations apply to Workers' Compensation claims, suits against negligent parties, and under PIP and uninsured motorist policies and for suits against different government entities. The Law Offices of Mike Murburg, PA have attorneys who have considerable experience in doing just these sorts of cases. Please refer to the attorney resumes on this website and select whichever attorney you believe is best to fit your needs in regards to this.

**32. Should I settle my Workers' Compensation case without using an attorney?**

If you do your own dental work or do your own surgery, you probably still should hire an attorney. If you or he/she does not have regular experience in such matters you will not know what the true value of your case is or what you are giving up. Remember, the insurance company is not there to protect or look out for you. Its duty is to the insured, the employer and the company's shareholders. You do not even come into the equation with the insurer, only to the extent that they can get you to settle cheap.

# PERSONAL INJURY F.A.Q.S. (Florida Personal Injury and Motor Vehicle Law)

"Sometimes in personal injury cases a financial recovery may cost a social security recipient loss of his or her social security and/or Medicare Medicaid benefits. Most personal injury attorneys do not understand this" – Mike Murburg

Mike Murburg received his Bachelor's Degree from Princeton University in 1977, graduated with honors from the Florida State University School of Law in 1986. He was thereafter admitted to practice law in Florida, Washington State and the United States Supreme Court. Before concentrating his practice on Social Security Disability and disability related matters, Mike was a successful trial attorney with over 80 jury trials which he handled the successful conclusion for his clients, winning almost 90 percent of the jury cases he tried.

Mr. Murburg has over 20 years experience dealing with questions from his disabled clients who have been injured as a result of someone else's negligence. The Law Offices of Mike Murburg P.A. do not actively pursue the representation of persons injured in accidents. However, we will at the request of our present and former clients, represent them in these types of cases or refer them to another attorney who is best set to represent them in their particular case.

### 1. What should I do if I am in an automobile accident?

If you are in an accident, it should be reported to your insurance company as soon as reasonably possible.

If you are injured at the scene, do not be afraid of obtaining medical care there. An emergency medical technician is well qualified to examine you. If necessary, go to the emergency room for diagnosis and x-rays to ensure there are no broken bones or internal injuries. Once they release you, it may be a good time to consult an attorney about your case.

During the period prior to making a demand to settle your case and before actual litigation in court, if we cannot get your case settled, we will be constantly updating your file to obtain current medical reports, correspond with insurance adjusters, and compile medical bills or property damage reports and bills to be forwarded for collection from the insurance carrier. We shall also identify and research actual and potential legal issues, obtain statements from witnesses when necessary and contact potential "Expert" witnesses for trial purposes when the need to do so becomes apparent.

## 2. Who will pay my medical bills and lost wages?

If you are an injured driver or passenger in a motor vehicle accident in the State of Florida, unbelievably it is your own auto insurance carrier, through your own Personal Injury Protection Benefits who is responsible to pay 60% of your lost wages, and 80% of your medical bills. This is true no matter who is at fault, and is payable up to an aggregate of $10,000.00 even if you were at fault; hence, the somewhat misleading term “No Fault” insurance.

During the course of your treatment, you may exhaust your PIP benefits. This usually happens when the total of your bills exceeds $12,500.00. So if you have health insurance, Medicare or Medicaid as well as PIP/no-fault benefits, please let your health care providers know and give them all the information necessary to bill that co-provider. Remember, your PIP/no-fault benefits only pay 80% of your bills up to a total of $10,000.00 coverage. The 20% is payable by your co-insurer (for example, Automobile Med-Pay, Blue Cross/Blue Shield, Aetna, Humana, Medicare, Medicaid) or by you out of pocket or eventually from your recovery should there be one in your case. As a consequence, it is always wise after you are injured to check in with your family doctor to apprise him of your treatment. It is important not to have him or her “out of the loop” since not only he/she is one of your most valuable witnesses if suit is filed, he/she may be called upon to make the appropriate referral for you to a specialist once your PIP/no-fault benefits are exhausted and payment for your medical bills is taken over by your co-insurer/health insurance provider.

Attorneys who practice personal injury law and put the client first, have found it financially favorable for our clients in the long run to obtain medical care through their co-insurer once PIP/no-fault benefits are exhausted. Even though your health insurer maintains a lien on your recovery, the lien is much reduced because of the lower cost of medical attention, surgery, hospital care, and pharmaceuticals that the co-insurers have negotiated with providers. This results in a greater net recovery for you out of an

eventual settlement. (For example, surgical facilities will bill you $10,000.00 per day if you are self-insured, but only bill a health insurance carrier or Medicare between $750.00 and $1,000.00 for the same facility.) Additionally, I have seen surgical bills of $30,000.00 paid at a rate of $3,500.00 by a health insurance carrier. The choice of where to get medical care and how to have it paid for is your decision. Please try and be wise with your choices and check on your potential bills for services and on your total bill from your providers so you know what your bills are. Your attorney should ask your PIP/no-fault carrier to advise him and you and to copy you with a Notice of Exhaustion of Benefits if, and when, your PIP benefits run out.

Additionally, you should confirm whether or not your health care providers are going to accept your private insurance, Medicare or Medicaid after your "No Fault" benefits are exhausted. If not, let your attorney know in writing so that he or she can advise you of your options.

### 3. If I am on Medicare or Medicaid, shouldn't they pay my bills?

If you receive Medicare or Medicaid payments on account of your accident, this may slow down our abilities to release funds to you at the time of settlement of your case. Federal law requires that Medicare and Medicaid be reimbursed for monies paid to physicians who treat as a consequence of your accident. Sometimes the procedure in getting Medicare or Medicaid to respond can take months. Often times Medicare does not come up with the right amounts, nor do they come up with the right doctors. You will have to be patient in determining these amounts and the waiting time that the additional investigation by Medicare and/or Medicaid may cause. If you have not done so already, you should provide my staff with a copy of your Medicare or Medicaid card for our file if you are receiving benefits from either or both of them so that your attorney can begin the process of obtaining information regarding any lien Medicare or Medicaid may claim in regard to your accident as soon as possible. The same is true with your private health insurance carrier who will also have a lien on your recovery for accident related expenses he/she have paid for.

During the period prior to making a demand to settle your case and before actual litigation in court, if we cannot get your case settled, we will be constantly updating your file to obtain current medical reports, correspond with insurance adjusters, and compile medical bills or property damage reports and bills to be forwarded for collection from the insurance carrier. We shall also identify and research actual and potential legal issues, obtain statements from witnesses when necessary and contact potential "Expert" witnesses for trial purposes when the need to do so becomes apparent.

### 4. How and when should my case be concluded?

In order to help conclude your case, your attorney must be in possession of sufficient facts to sustain our position before a demand to settle your claim or lawsuit is filed. The length of time it takes to reach the point of filing a lawsuit will vary from case to case. Most cases are settled before it is necessary to file a lawsuit. Others are settled at "mediation" or later "at the courthouse door" after the claim has been filed and just before the trial actually begins. The personal injury staff and your attorney are continually working to successfully settle disputes without resorting to trial. However, everything that we do contemplates the possibility of trial so that our clients and your case are properly preserved and protected if that circumstance becomes a reality. Insurance companies respect this and know that this firm is not afraid to try these cases thereby allowing us to recover what you deserve.

**5. What should I tell my doctors?**

At some point in time, you will be visiting doctors in reference to the injuries you sustained in this case. Patient history is of the utmost importance. You should give each of your treating physicians a written and exact description of how the accident in question occurred and whether or not you had any prior similar or dissimilar injuries or accidents as well. Please take your time and be accurate and advise him of any and all accidents and injuries for which you sought care. Do not try to hide anything. Your honesty and integrity are the most important part of your case. Moreover, the insurance companies will know of just about all instances in which you sought medical care. Do not try to hide anything. Even if you are not a liar, a good defense attorney or insurance adjustor can make it look that way if you are careless about your injury or medical history. So take your time, think about the questions you answer and be careful.

Not only will it be important that you keep all medically related appointments with your doctors, you should also keep your doctor fully informed with regard to all progress and problems associated with our medical recovery. Some orthopedic and neurological problems come and go. Please communicate with your doctor and let your physician know about your "bad" days even though you may be experiencing a "good one" in his office. It is also helpful if after each visit with the doctor you keep a diary or write notes to yourself with regard to what the doctor has said concerning your progress or prognosis. Please note in your diary only pains or symptoms you may experience so that you may relate them to your physician and to me on a later date. Once again, copies of all medical bills and reports should be forwarded to our office so that they may be submitted to your insurance carrier or made a part of your file. If you take any over-the-counter medication for your accident related injuries, please keep copies of the receipts for these medications and all empty bottles until the case is concluded.

During the course of your treatment until the resolution of the case, we suggest that you not go on any rides at any attractions. These rides have warnings about persons with injuries to the back and neck not riding on them and as is often the case, people try them and get re-injured. That will also deduct from the value of your case. Only healthy

people should go on these rides anyway. Additionally, should you brave the ride and it comes up during litigation that you had gone on the ride, the insurance company will try to make it look like there is nothing wrong with you to the extent that you are able to go on amusement park rides and not suffer any consequences, hospitalizations or additional medical treatment subsequent to those attraction rides. As a consequence we advise against going on to any of the rides at any of the attractions locally or otherwise.

**6. With whom must I communicate about my accident?**

After having retained a law firm to represent you, you should not discuss the nature of your claim or any facts surrounding it without first talking to us. Apart from the filing of a lawsuit, you have the right not to communicate with anyone. Do not take that right lightly. Please keep your attorney advised of all developments which relate to your case. This information may be related by telephone or mail to the personnel in our office and usually will not require a personal interview unless you feel that it is necessary or it is requested by our office. Your attorney will be sending you insurance disclosures early on in your case and will advise you of important developments regarding the progress of your case. Please remember that a good personal attorney is constantly involved in working on active cases for all of his/her clients. Time and ability to devote proper attention to our cases has a direct bearing on our effectiveness. Office personnel are trained to take messages and to relay routine information promptly. One can understand that if each client called to speak with an attorney each week, the attorney would spend most of the time on the telephone and be unable to work with files, prepare legal motions or documents, or attend trial and court hearings. You should be therefore cooperative and understanding.

**7. What is a "Letter of Protection," and how will it affect my case?**

A Letter of Protection will protect the bills of your healthcare provider. If you want your healthcare provider's bills to be protected and the provider to forebear from the collection process, you will be asked to sign a Letter of Protection for that healthcare provider.

This Letter of Protection will guarantee that your medical bills from the provider shall be paid out of your judgment or settlement in this case. The issuance of a Letter of Protection may prevent these bills from being negotiated downward in the future and may have some negative impact on medical testimony offered at trial (if any) by the provider.

**8. If I am injured, am I entitled to a financial recovery, even though I was not at fault?**

The answer is yes. However, how much, and whether or not you can collect on that entitlement may be another story.

Over 20 years ago, Florida's legislature passed the "No Fault Law" to keep non-serious cases out of court. Hence, in order to file a claim or lawsuit for your pain, suffering, inconvenience and/or mental anguish, you must be diagnosed by a physician (medical doctor, doctor of osteopathy, doctor of pediatric medicine or doctor of chiropractic medicine) with a "permanent injury." Without a diagnosis of "permanent injury" your recovery is limited to your out-of-pocket medical expenses and accident-related future medical expenses to the extent they exceed your personal injury protection benefits. You are also entitled to provable past and future accident-related lost wages to the extent they exceed your PIP benefits.

Sometimes there is insurance (bodily injury insurance) to cover these damages from the person who caused the accident. If he or she is uninsured or underinsured (i.e. has some bodily injury insurance but not enough to cover your damages), you will need to look to your own policy or the policy of the driver of the car in which you were injured to determine whether there is "uninsured motorist coverage" ("U.M.") or "underinsured motorist coverage" ("UIM"). This is insurance that may be used to cover your losses in such a situation. If you are covered by U.M. or UIM, you will need written permission to settle with the person who caused the accident or his/her insurance company and to obtain your UM/UIM insurers written waiver of subrogation. This is something your attorney should do for you and is one of the reasons why an attorney should be retained.

**9. When should my lawsuit be filed?**

The decision to settle a case without a trial is your decision after receiving all relevant legal advice from your attorney. If the amount offered is not enough for you to settle your case, you have the right to a jury trial.

In Florida, there are consequences and costs to filing a lawsuit, however. If and when a lawsuit is filed, we are be busy working in the preparation of appropriate legal motions and responses, preparing for and attending depositions (sworn statements) of both our witnesses and those of the other side, mediations (settlement conferences), and trial preparation including securing the attendance of witnesses, preparation of any required trial briefs and exhibits, and preparation for a trial of the issues.

**10. If a lawsuit is filed, I have heard that I must attend and give a "deposition". Exactly what is that and how should I prepare for it?**

If you have never been to a deposition before you may ask, "What is a deposition"? Sometimes on television you can see courtroom scenes in which surprise witnesses are called with important testimony. In the real world courts don't work that way anymore. In today's world each side has an opportunity to question the parties and important witnesses of the other side in a question and answer session called a "deposition". This is

what you have been scheduled for. Even though a deposition is an official court proceeding, you should not think of a deposition in the way you think of actual testimony in court before the jury. There are a lot of differences between the two. For example, if you are in the courtroom, you would be trying to persuade or convince the jury of the believability and importance of your case. In a deposition, by way of contrast, you are there only to answer the questions put to you by the other side. You will be placed under oath to tell the truth, and of course, that is the most important thing for you to do. The other lawyer will ask you questions, but there will be no judge or jury at the deposition. Your testimony will be treated as the truth for virtually all purposes after you are deposed.

As your lawyer, I will be there with you. I will be there not only to ask you specific questions but to make sure that the questions the other side asks you are fair, properly worded and not "trick" questions. I will most likely not ask you any questions at all, because, again we are not there to present your case at that time, but are there only to answer the other side's questions.

You may ask why they want to take your deposition. First, the other side does not know you and wants to get your side of the case. Next, they want to see how you look, how you answer the questions, and in general what kind of witness you will make in your own behalf. This is important, because if they believe that you are going to be an effective witness, they will place a higher value on your case.

The most important thing that the other side wants is to be able to catch you in a lie or a misrepresentation of the truth. The attorney taking the deposition will ask you many questions to which they already know the answer but they want to see if you give the correct answers. If they should happen to catch you in some kind of a lie or misrepresentation, they will be able to point that out to the jury or judge later on, and your case will lose all or most of its value. Judges and Juries simply do not award substantial money to people who have lied or misrepresented the facts of their case.

You may also inquire about the questions you will be asked? Because the Florida Rules of Civil Procedure permit the other side to ask almost anything that they want to ask in a deposition, it is impossible to precisely predict what questions they will offer. However, most depositions cover the following categories:

1. Background: Where you grew up, went to school, work history, previous accidents, previous claims or lawsuits filed, and previous injuries or significant other injuries.
2. Accident facts: Where you had been, where you were going, what you had observed before the accident, how the accident occurred, and what conversations went on afterwards, etc.
3. Injury and Treatment: How you were hurt in the accident, what areas of your body bothered you, what medical treatment you sought, and what treatment has been given. They also are going to want to know about any pre-existing injuries or treatment that you had received prior to your accident.

4. Effects of the injury: The attorney asking the questions will want to know whether the injury has interfered with your work, how it has effected your home life and activities, and what you have trouble doing now or can't do now on account of the injury.

You may ask how should I answer the questions asked of or posed to me. There are two simple rules for answering the questions of the other side. First, it is very important that you listen to the whole question and make sure you understand it. If you don't understand the question, you may say so and the question will be repeated or rephrased. When you answer, your answers will by recorded by a court reporter. Please answer the questions asked of you in a direct manner. Please don't use the words "uh huh" or "un uhs", since these expressions cannot be easily recorded and have no value when placed on the record since they can just as easily be interpreted as a "yes" or a "no" answer. If the answer is a "yes" or a "no" answer, please use "yes" or "no" in your replies. Please do not nod your head yes or shake your head no without giving a verbal response of either "yes" or "no" to the question.

The second very important rule is that you give only the information that is asked in the particular questions that are put to you. Keep your answers as short as possible while still answering the question fairly. Remember, the more you say, the more the other side has to use against you. Therefore, confine your answer only to the question asked; do not volunteer any information. If the attorney asked you what color was the sky, you may answer the sky was blue. Do not volunteer that the clouds were white, that the trees were green and that the birds were singing, and that the children were playing out in the yard. Keep your answer short and sweet and to the point. As Officer Joe Friday used to say, give "just the facts ma'am/sir, just the facts."

During the deposition you may be inclined to ask me questions. We can go off the record and do this. Please just tap my shoulder and say, “Mike, can we talk?” If need be, we’ll go off the record. Since our conversations in my office or outside my office are confidential and privileged, I am instructing you at this time that I will be raising that privilege and you should not divulge any of what I have said to your or what you have said to me during your deposition. If we had referred you to a physician, that is privileged and confidential as well. As a consequence, please just tap my shoulder and say, “Mike, can we talk?” if the question of how you go to Dr. Smith, Jones, is asked. Again, what you have told me and what I have told you is not discoverable by the defense and it should not be volunteered at deposition by you.

You may also ask what kind of attitude should I have in giving my deposition. In answering this question you should not think that the other lawyer is your enemy. In fact, you should be friendly and cooperative in your answers, and it won't hurt to smile. The reason for this is that if the other side understands that you are a nice person they will put a higher valuation on your case than if they think you are not going to make a good impression on the judge or a jury. Of course, if you are relaxed and just being "a nice person" you will feel better and you actually give better answers, keeping in mind the instructions that I have given you. Please be friendly with the attorney who is taking

your depositions. However, please remember he is not your "buddy." Often attorneys will try to get overly friendly with you and make you say things that you wouldn't ordinarily say at depositions. The bottom line is, please be warm and cordial.

Additionally don't try to figure why a certain question is being asked; this will just take your concentration away from answering the question. Think about the questions before you answer and remember to answer the question fairly but only answer the question that is asked.

On rare occasions I may object or instruct you not to answer the question at all. If that happens, don't worry about it. If I object, let me finish my objection and then answer the question. It is my job to make proper objections on the record to be preserved for a judge to consider later on. If I instruct you not to answer a specific question, do not answer that question.

There are some common traps that defense attorney's use to try and trip people in their depositions. The first area that normally trips deponents up concerns old claims or injuries. As you know, computers these days contain about everything you've ever done. The insurance companies have access to most computer information and they will dig up any and all insurance claims that you have ever made. They will also know about previous injuries, and they will know many of your medical conditions, especially those for which you may have had a health insurance claim. Nevertheless, the lawyer will ask you in detail about these, hoping that you will try to hide or misrepresent information about one of them. Again, if that happens, the lawyer will be able to point that out to the jury or the judge, to try to prove that you are not a truthful person. When you are asked about prior injuries or medical conditions, it is very important that you be as complete and as accurate as you can be about previous injuries, accidents, insurance claims and prior medical treatment. It is of the utmost importance that you do whatever you can to refresh your memory prior to the deposition, speaking with family and friends concerning any injuries you may have received. The attorney for the insurance company or defendant that will be deposing you will know many of your medical conditions and accidents, especially those for which you have made a motor vehicle, homeowners or health insurance claim.

You may also be asked about any arrests or convictions you may have had. Again, the above advice about being complete and honest applies. All information about arrests or convictions is available, and I assure you that the insurance company will have that information. Don't try to hide such information or misrepresent it. If you do, the results will be fatal to your case. Please note that in Florida, if you have not been adjudicated guilty of an offense, then that offense charged does not constitute a conviction. If you have any questions about this, please let me know, and I will clarify your questions before the deposition.

The attorney taking your deposition will be interested if your activities before your accident have been affected by your injury. Sometimes clients will say that they cannot

do a certain activity now, when what they really mean is that they don't do the activity very often or that when they try it they don't do it as well as they did it before the accident. Be careful about that; you should say that you cannot do a certain activity only if you absolutely cannot, and do not, and have not performed that activity. Remember, it is very common these days for the other side to "spy" on you and film your activities with a video tape. It is not uncommon for the insurance companies to video tape you early on in your claim and ask you questions in deposition concerning certain activities you may have been videotaped doing. They will be delighted, if you say that you can't do the activity when they have evidence that you can.

In preparing for your deposition you must remember that your manner of dress is important. Since you are trying to make a good impression, you should dress as if you are going to Court or even to church. Men should dress in a coat and tie if possible and a woman should be in a conservative outfit appropriate for church. If it is practical or appropriate to do so in your case, you should visit the scene of the accident before testifying. As you visit the scene, go over in your mind how the accident occurred or who did what and when.

Finally, in order to summarize my instructions to you on how to act while giving your testimony I would advise you as follows:

Tell the truth. Never lose your temper. Don't be afraid of the lawyers. Speak slowly and clearly. If you don't understand the question, ask that it be explained or repeated until you do understand the question. Answer all questions directly, giving concise answers and stop talking. Never volunteer any information. Wait until the question is completely asked, then answer it and stop talking. If you can answer a question completely with a "yes" or "no" answer please do so. And stop talking. Stick to the facts and testify only to that which you personally know. Tell the exact truth about your injuries or losses. Do not minimize or exaggerate. Testify only to basic facts and do not attempt to give opinions or estimates of time and distance unless you have good reason for knowing such matters.

Additionally, if you don't know an answer, just say so. Some witnesses think they should have an answer for questions asked. You cannot know all the facts in your case, and you do yourself a disservice if you attempt to testify to facts with which you are not acquainted. It is imperative that you be honest and straight forward in your testimony. Also if you do not recall at the time the question is being asked and you are giving an answer, please tell the attorney that you cannot recall "at this time".

Don't try to memorize your story. Justice requires only that you tell your story to the best of your ability. You must remember that the most important aspect of your case is you and the appearance that you make. If you give the appearance of earnestness, fairness and honesty, and if, in giving your deposition, you keep in mind the suggestions made

here, you will be taking a great stride toward a successful and satisfactory completion of the litigation of the suit or claim that has been filed in your behalf.

Most people don't find depositions unpleasant, and there is no reason to be nervous. If you follow the above advice, you will give a good deposition and help your case. Above all, tell the truth.

**11. I have read that 90% of lawsuits filed are settled in "Mediation." What is Mediation?**

Since many people may not be familiar with the legal terminology or the process, the information that follows may be of some help to you on the process, procedure and potential outcome.

First of all, it is important to understand that mediation is not to be mistaken for just another form of arbitration. The goals of the two differ considerably. It is sufficient here to observe that arbitration is designed to provide an alternate dispute resolution forum for a limited class of less complex civil cases at the early stages of the case. In contrast to that program, mediation is designed to serve the interests of the more complex civil case which has not been arbitrated, which has completed most, if not all, discovery requirements and is or ready to be set for trial

**12. Why is a case mediated?**

It is important to understand that the Court has coordinated its trial docket in an effort to ensure that case will be tried as scheduled. However, given the statistical reality that over 80% of all scheduled trials settle prior to the morning of trial, the Court and the attorneys for the parties have a duty to the other cases on its docket to ensure that all possible avenues of settlement in this case are explored prior to trial.

The statistics demonstrate that nearly 70% of all mediated cases settle at the mediation conference. Settlement rates in Federal Court have been significantly higher. Consequently, the Florida Supreme Court and the Federal Court for the Middle District of Florida have determined that mediation is the best and most appropriate forum in which to consider the possibilities for settlement in a particular case.

**13. What is a Mediation?**

Mediation is a supervised settlement conference presided over by a qualified, certified and neutral mediator who suggests alternatives, analyzes issues, questions perceptions,

uses logic, conducts private caucuses, stimulates negotiations between opposing sides and keeps order.
Mediation is also a docket and litigation management tool which has proved successful in securing a high percentage of settlements on an amicable basis without the expense, exposure, and uncertainty of trial. Mediation has proven to be most effective when it is conducted within 45 days of the scheduled trial date, when discovery is substantially complete, and the parties are fully informed as to their respective positions. So, if you have seen any new physicians or have received any new bills, please let us know.
The mediation conference is conducted either in a courtroom or conference room. During the mediation process, private rooms or offices are made available for individual "caucuses," meetings, if you will, and conferences.
The mediation process itself is intended to be informal in nature, which the actual ebb and flow of the process is structured by the mediator. Unlike arbitration, which results in an award and possible judgment, the only result of the mediation conference is the agreement of the parties. Although the mediation process is inherently flexible, as a rule, the following guidelines apply to the conduct of the mediator:
The mediator will:

1. Be impartial.
2. Suggest alternative.
3. Have private meetings or caucuses with the attorneys, parties, corporate representatives, and claims professionals.
4. Assist in clearly identifying the issues.
5. Privately debate each side's logical basis and perceptions.
6. Respect confidential and/or privileged information.
7. Allow the parties to negotiate.
8. Guide the parties and counsel in finalizing a specific settlement agreement.

The mediator will not:

1. Act as a judge or arbitrator.
2. Rule upon questions of fact or law.
3. Render a decision or award.
4. Hear testimony.

In order for trial counsel and the parties to include corporate representatives and necessary claims professionals, they are required to appear and participate in the mediation process and must attend the conference with complete authority to compromise and settle the action. Participants are required to remain and participate in the mediation conference until a settlement is reached, the parties, with the consent of the mediator, agree to continue the mediation conference to a date certain prior to the regular schedule trial date, or the mediator declares an impasse. As a rule, the mediation process usually lasts somewhere between 2 to 5 hours.

**14. Who are the mediators?**

Court appointed mediators have been certified by either the Florida Supreme Court of the Chief Judge of the Middle District of Florida pursuant to Local Rule 9.02. Each mediator has demonstrated the unique qualities required to effectively facilitate the mediation process, and each has already completed the 40 hour Florida Circuit Court Mediation Certification program.

**15. How are mediators compensated?**

Unless otherwise agreed by the parties, the mediator is paid between $200 to $250 per hour of service, and the cost is borne equally by the parties. Experience has shown that the average cost of the mediation conference is approximately $200 per party.

**16. What are the advantages of mediation?**

Advantage for the Court:

1. Docket management and control.
2. Resolves the case without the necessity of additional judicial labor for trial.
3. The dispute is resolved early and not on the eve of trial, thereby allowing the Court to schedule other cases in the allotted time.
4. Voluntary settlements as a result of bargaining by the parties usually do not need post-trial enforcement proceedings or appeal and resolve all outstanding issues between the parties.
5. Citizens and attorneys are more satisfied with the "system."

Advantages for the Attorneys:

1. Enables them to negotiate a settlement which may be more favorable than their expected result at trial.
2. Facilitates negotiation - forces the creation of an event at which both sides must negotiate in good faith.
3. Accomplishes the goal of the client without a disproportionate expenditure of attorney's fees.
4. Client satisfaction - enables the attorneys to deliver a product (resolution of the dispute) favorable to their client with which their client is satisfied.
5. Provides more effective use of the attorney's time.
6. Protection of having the client participate in the negotiation process.
7. Durable agreement - no appeal - no collection problem.
8. Prevents settlement negotiation distraction during trial process.

Advantage for the Parties:

Allows them some management control over the resolution of the dispute.
Prevents the unlimited exposure and uncertainty of a trial.
Allows them to exert some informed direct influence over the outcome of the dispute after observing the other attorney, the other party, and hearing a capsule discussion of the case with a neutral outsider.
Avoids the expenses of final trial preparation and trial.
Allows the party to bargain through counsel for certain key elements which are extremely important in exchange for the other elements which are less important. The Court would make a decision without knowledge of or regard for these key elements.
Each side gets to see the other's best offer and the parties can decide to take it or litigate.
Enables a party to stop an expenditure of time and personal involvement in the litigation and therefore, exert energies to other business pursuits or other normal activities.

## 17. Will my statements at mediation be confidential?

According to the Mediation Confidentiality and Privilege Act, effective July 1, 2004, mediations conducted in the state of Florida are subject to new provisions relating to confidentiality and privilege.

Briefly, the law creates the "Mediation Confidentiality and Privilege Act" that applies to any mediation:

1. Required by statute, court rule, agency rule or order, oral, or written case specific court order, or court administrative order;
2. Conducted under the act by express agreement of the mediation parties; or
3. Facilitated by a mediator certified by the Supreme Court, unless the mediation parties expressly agree not to be bound by the act.

The mediation parties may agree in writing that any or all specified provisions of the act will not apply to all or part of a mediation proceeding. The terms "mediation participant," "mediation party," "subsequent proceeding," and "mediation communication are defined, the latter as "an oral" or written statement, or nonverbal conduct intended to make an assertion, by or to a mediation participant made during the course of a mediation, or prior to mediation if made in furtherance of a mediation." In addition, it should be noted that the commission of a crime during a mediation is not a mediation communication.

Except as otherwise provided, all mediation communications shall be confidential and a mediation participant shall not disclose a mediation communication to a person other than another mediation participant or a participant's counsel. A violation of confidentiality may be remedied by a civil action or, if the mediation is court-ordered, may also subject the mediation participant to sanctions by the court, including, but not limited to, costs, attorney fees and mediator fees. The civil action, which may be brought by any party, for

a knowing and willful disclosure of confidential information, could subject the violator to equitable relief and compensatory damages, as well as attorney fees and costs.

Each mediation party has a privilege to refuse to testify and to prevent any other person from testifying in a subsequent proceeding regarding mediation communications.

The law provides exception to confidentiality and privilege in relation to the following communications:

1. A signed written agreement reached during a mediation (unless otherwise agree)
2. A communication that is willfully used to plan a crime, commit, or attempt to commit a crime, conceal ongoing criminal activity, or threaten violence.
3. The making of a mandatory report of child abuse or neglect or elder abuse, neglect or exploitation, solely for the purpose of making the mandatory report to the entity requiring the report.
4. A communication used to report, prove, or disprove professional malpractice or misconduct occurring during the mediation solely for the purpose of the internal body investigating the misconduct or the malpractice proceeding.
5. A communication establishing or refuting legally recognized grounds for voiding or reforming a settlement agreement reached during a mediation.

There also is no privilege and no confidentiality if it has been waived by all parties. Communications subject to disclosure remain confidential and are not discoverable or admissible for any other purpose, unless otherwise permitted by law. Information that is otherwise admissible or subject to discovery does not become inadmissible or protected from discovery by reason of its disclosure or use in mediation.

Other provisions of the mediation law extend mediator judicial immunity to trainees fulfilling mentor ship requirements for mediator certification by the Supreme Court and provide limited immunity for a mediator in relation to any non-court-ordered mediation within the scope of the Mediation Confidentiality and Privilege Act.

## 18. What does a mediator report to the Court?

Within five days of the conclusion of a mediation conference, the mediator files a mediation report indicating whether all required parties were present. The report also indicates whether the case settled, was continued with the consent of the parties, or whether the mediator declared an impasse, which means that the case did not settle.

## 19. What if I am injured in a "Slip and Fall" Accident?

If you are injured in a slip and fall, you should report the injury to the owner or occupier of the place where you were injured. Get the names and addresses of any witnesses.

Photograph the area and cause of your fall. If the defect was caused by the owner of the property agents or assigns there is liability. If someone else left something for you to trip over, that person is liable. The landlord/renter will be liable, if the person knows of the defect and did not fix it or should have known of the defect through reasonable inspection but failed to act reasonably in conducting the inspection or failed to conduct the inspection. Remember that just because you are injured, someone is not automatically at fault.

**20. If I am injured in a slip and fall who will pay for my bills?**

Good question. If you are covered by private health insurance, Medicare, Medicaid or the VA, you are covered, but must repay your insurer from the proceeds of your settlement, if any, for accident related expenses. Sometimes, a landowner will have "medical payments coverage", usually less than $5,000.00 to pay your accident related medical bills no matter who is at fault. If the accident happens at work, your workers compensation carrier should be liable. Otherwise, you should consult an attorney and ask him about a "Letter of Protection" or find that section on the website.

**21. In Florida, if I am disabled and a Medicare recipient, can a physician legally charge me more than Medicare will allow?**

No. Florida Statute §456.056, Treatment of Medicare Beneficiaries, provides in pertinent part of the following:

(5) Any attempt by a primary physician or a consulting physician to collect from a Medicare Beneficiary any amount of charges for medical services in excess of those authorized under this Section, other than the unmet deductible and the 20 percent of charges that Medicare does not pay, shall be deemed null, void, and of no merit.

**22. So, if I am in an accident, what should I do?**

You may have only a limited amount of PIP benefits, so in writing, advise your physician that after your PIP benefits are exhausted, they should bill Medicare for their services after your PIP benefits run out; otherwise you may be forced into litigation over your bill.

**23. Does Florida law define me as a Medicare recipient?**

Florida Statute Section 456.056 defines "Beneficiary" as a "beneficiary of health insurance under Title XVIII of the federal Social Security Act." (42 U.S.C. § 1395 et seq., Health Insurance for Aged and Disabled).

If I become a Plaintiff, and I am a Medicare Beneficiary and sustain injury, who is liable for damages including the amounts that treating physicians charged under contract/letters of protection?

You are liable to your physicians for bills you incur even though the person who caused you injury may be liable to you to compensate you for those damages. If you assign your claim in writing to your physician, that physician has your claim for the bills you incurred to him on account of someone else's negligence but this recovery is a limited one.

Pursuant to Florida Statute §465.056 treating physicians are limited to charges authorized by Medicare as found in 42 U.S.C § 1395 et seq., which provides that physicians may charge only a limited amount above the Medicare-Approved Amount when the physician does not accept assignment of the claim. See 42 U.S.C. § 1395w-4 et seq., 42 C.F.R. §§ 424.56 and 414.48.

Medicare set the limiting charges for years subsequent to 1993 at 115% of the Medicare-Approved amount for unassigned claims. See 42 C.F.R §414.20 and 42 C.F.R. §414.48 (if the physician accepts assignment of the claim, the physician is limited to only 100 percent of the Medicare-Approved Amount).

Moreover pursuant to 42 U.S.C.A § 1395w-4 (g) no Medicare Beneficiary is liable for payments of any amounts billed for service in excess of the limiting charge.

Physicians who are enrolled with Medicare are bound by agreements not to charge Medicare Beneficiaries individually for services that the individual could have had covered under Medicare. See 42 U.S.C. §1395cc. So, notify your physician immediately that you are a Medicare recipient so that he is not stuck holding the bag for his services or expecting you to make payments that Medicare would otherwise make.

**24. How can a physician go about legally charging me more than Medicare will pay?**

If a physician seeks to have a Medicare Beneficiary held liable as an individual for charges that are in excess of the Medicare-Approved Amounts, the physician must meet the requirements of 42 U.S.C. §1395a that mandates a written contract between the Physician and the Medicare Beneficiary must be entered into and signed by both individuals, and that the contract set forth the specific services to be provided, that the Medicare Beneficiary will not submit a claim to Medicare, that the Medicare Beneficiary understands he or she will be responsible for payment of services and that Medicare will not reimburse him or her for those services, that the Medicare Beneficiary acknowledges there exists limits under Medicare regulations limiting charges to specific amounts, that the Medicare Beneficiary has the right to services provided by other physicians who would limit their charges to Medicare-Approved Amounts, and that the physician indicate whether or not he or she is a participant in the Medicare program. If no contracts that

meet these requirements exist, then your physician may not collect more then the Medicare allotted amounts.

In addition to the contractual requirements, the physician must notify Medicare by way of affidavit stating that the physician will not submit a claim under Medicare for services provided to the Medicare Beneficiary for at least two years after executing the contract. If the physician fails to abide by the regulations and codes under 42 U.S.C. § 1395 et seq, the physician may be subject to sanctions including fines amounting to two to three times the excessive charge, removal from the Medicare program, or refunding of any payments made by the beneficiary that are excessive and assessment of $2,000.00 for each instance of excessive billing.

It is obvious that Medicare does not want Medicare Beneficiaries to be taken advantage of by physicians circumventing the Beneficiaries' right to have the charges limited by Medicare.

**25. So, how would this work out in an accident case involving a Medicare Beneficiary?**

For example, in an accident case, it is not unusual for physicians to bill the injured patient in excess of Medicare paid services because there is a financial incentive to do so. The American Orthopedic Institute billed $35,417.47 over the limiting charges allowed by Medicare for the arthroscopic surgery for knee meniscus tear and related services. Dr. Smith billed $779.44 over the limiting charges allowed by Medicare for a single office visit and Calcium Chiropractic and Rehab billed $2481.28 over the limiting charges allowed by Medicare for chiropractic care and services. Billing amounts for these physicians exceed $46,018.35, which exceeds the Medicare-Approved amounts by at the least $40,000.00. The actual Medicare-Approved amounts equate to only about $7,440.00 for these services.

**26. How do courts limit these recoveries from physicians in Florida?**

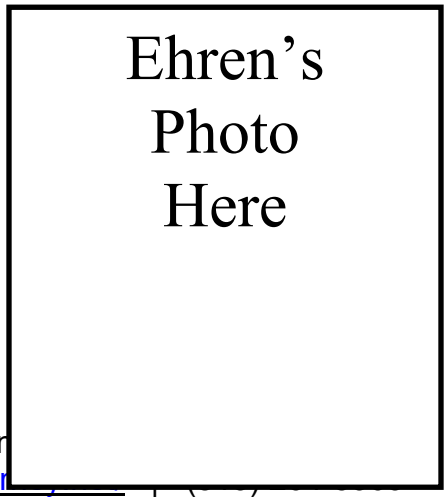
The Second District Court of Appeal addressed the admissibility of charges exceeding Medicare amounts in Cooperative Leasing Inc. and Domer v. Johnson, 872 So.2d 956, (Flat 2d DCA 2004). The facts in Cooperative were that a motorist was injured in an automobile accident and the trial court allowed into evidence bills for all medical expenses. The bills were in excess of benefits paid by Medicare. The Second DCA ruled that the excessive billing was inadmissible because the plaintiff was not liable for the excessive billing pursuant to Title 42 U.S.C. §1395 and precedent. In citing the U.S.C., the Second District determined that the plaintiff's medical bills were paid by Medicare at the Medicare-approved amounts and that the physician could not recover from the plaintiff personally. The Second District goes on to provide precedent that the plaintiff is entitled to compensation for reasonably valued medical care and found that the Medicare

amounts paid to the physicians were customary and reasonable. This is also the basis for approved amounts under 42 U.S.C. §1395w-4. Therefore, any amounts in excess of the Medicare-approved amounts would allow the plaintiff to receive a windfall by recovering "phantom damages". Id, at 959. In its ruling, the Second District goes on to provide that the difference between what the physicians charged and the Medicare-Approved Amounts are not a collateral source that would be deducted as a set-off post verdict. Id. At 960.

Moreover, all billing of the above physicians that do not meet the requirements for contracting with a Medicare Beneficiary and/or that are in excess of the Medicare-Approved Amounts are null, void, and of no merit as a matter of law pursuant to Florida Statute §456.056 It is of the utmost importance, therefore that if you are involved in any accident, you let your treating physician know you are disabled and on Medicare, so that you do not create any outstanding bills or bad-will by failing to tell your physician up front to bill Medicare, especially if you are involved in an accident other than one involving a car or other passenger vehicle

**27. If I have been injured in a motor vehicle accident, will you evaluate my case and contact me?**

Yes, please complete the intake form provided below. Once you have completed the form, send it to us electronically to support@disabilityattorney.net or by fax at 813-514-9788, and we will get back with you as soon as possible



# VETERANS' PREAMBLE

On June 9, 2008 our son and brother, Private First Class Norman M. Murburg, III died during his Special Forces training exercises at the John F. Kennedy Special Warfare Training Center Camp McCall, Ft. Bragg, North Carolina. He died while in his special forces training due to heat exhaustion during a 104 degree three day heat wave on the last day of that training. The death could have reasonably been prevented. Mike's son literally gave his last breath and measure for his country. Initially the Cause of death was ruled "envenomation by poisonous snake." His father Mike, our founder, did not believe the conclusion he was given. Though fighting grief and a retinal cancer which has left Mike partially blind, with help from Congressman Bill Young and his wife Beverly and the help of the St. Petersburg Times and Fox News, Mr. Murburg had the cause of death reviewed and investigation reopened. This ultimately led to the Army withdrawing the original cause of death and the termination of the chief pathologist who performed the autopsy and concluded envenomation as the cause of death. During this time, Mr. Murburg also discovered that the Army had let him bury his son without all of his organs. The organs were returned and finally re–interred with his son. With Congressman Bill Young and his wife Beverly and Mike's Law partner (and Ehren's surrogate mom) Carol Wilson present, Mr. Murburg was subsequently given a full report and apology in person by General Peter W. Chiarelli,-U.S.Army Vice Chief of Staff and Special Forces Lt. General John Mulholland, Commander in General Army Specialists, Brigadier General Coleen McGuire-Provost Marshall General of the U.S. Army and head of the US Army Criminal Investigation Division and Lt. General Eric Shoomaker-U.S. Army Medical Commander and Surgeon General of the U.S. Army and Capt. Craig Mallak, Armed Forces Medical Examiner at his ranch in rural Pasco County, Florida in 2010. The Attendees there vowed to have already made and to continue permanent changes that contributed to the death of Pfc. Murburg and the horrible aftermath in hopes that his death would mean something and help other soldiers to live. Only time will tell if that is the truth. Until the last day, Mr. Murburg will be a sceptic of anything that just doesn't set right. The complete story line can be Googled under Pfc. Norman Murburg, III.

"Ehren" as we and his close friends called him was an 18-Xray (18X10, Company D, STU, Support Battalion SWC, Ft Bragg, NC) and died in such a way that his nickname Ehren, (honorable) would have indicated. His one grandfather Lt. M. Goldblatt was a US Army test pilot and his other, Lt. Cmdr. N. M. Murburg, a Navy UDT/frogman, amphibious ranger and a WWII founding father of what would some day come to be

known as the Navy Seal Teams. Ehren had an MAT score of 139/140 and was proud to have been an infantryman, someone "who could do anything" in his own words, Airborne and part of US Army Special forces and the Green Beret program. He had left the University of Florida as a Bright Futures Scholar to join the Army become a member of the Special Forces, and fight terrorism in Afghanistan where he would have been at "the head of the spear", a place where he could the most good "for my country, for my children and my children's children". Ehren was an automatic weapons specialist and after his Green Beret Training, would have soon been on his way to medical training to become a Medic and to rejoin his unit. Ehren turned down the opportunity to go to West Point so he could become a Green Beret first and fight with his fellow Green Berets. His goal was to serve his country and to someday return to the University of Florida to complete his Pre-medical studies and then go onto medical school. His loss was a loss to us all, his family, his unit, and his country. Like any good soldier he died with his weapon in his hand. We were and are so proud of him. There will never be another like him. Why do our best die ever so young.

Having lost such a young man, such a son, both Carol and Mike renewed their obligation and commitment to help and to serve our Veterans in any way that they could. It helps make sense of the loss. Where families have suffered the losses, there must be some way to help. As a consequence, the Law Offices of Mike Murburg, P.A. will review, as they are able, the poignant issues concerning the service connected claims of all of our disability clients and the claims of all those disabled Veterans who may seek such advice. Hopefully, posthumously, this will help make Ehren as proud of us as we are of him. We recognize his ultimate sacrifice and that of our servicemen and women. We pledge to fight as hard for our disabled Veteran clients as hard as they have fought for us. We can only stand in your shadow, not in your shoes. You have no equals.

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# V.A. FREQUENTLY ASKED QUESTIONS AND ANSWERS

**1. What are Service Connected Veteran's Disability Benefits?**

Service Connected VA Disability Benefits are benefits due to a person who was in the US Armed forces who has suffered an injury or physical or mental limitation that was a result of his/her service.

**2. Does the award of these benefits depend on my income or assets?**

Veterans' service connection disability is not dependent on the amount of money or income you receive or on any assets you have.

**3. Can I collect both Service connected VA Disability and Social Security Disability?**

Yes. The two are not mutually exclusive. You can collect both simultaneously if you are eligible.

**4. Isn't this "Double Dipping"?**

Yes. You are a Veteran. You earned it.

**5. If I file for Social Security disability, will it help in my VA case and visa-versa?**

Yes. Federal Administrative Law Judges, like the Social security Administration's Administrative Law Judges and the VA Judges who will decide your respective claims, must give "substantial deference" to the final determinations of another federal administrative agency. Both the SSA and the VA are federal agencies. So when you get

your award letter from either the VA or the SSA, file it in the case that is still pending. It will help.

**6. Are there other types of VA Benefit Claims that Mike Murburg, P.A. handles?**

There are other kinds of veteran's benefits, other than service connection benefits. This office only handles service-connected claims. For information about all Veterans disability claims, please see http://www.vba.va.gov/bln/21/index.htm.

**7. What do I need to have in order to make a claim for VA Disability benefits?**

First of all you must have a current medical condition in order have a claim for these benefits.

**8. When does this condition need to begin?**

You must have a condition that began during your military service or was aggravated by your military service.

**9. What about conditions that I notice that have developed after I have left the Service?**

You may also claim disability benefits if you suffer from a disability that began many years after you were discharged but was caused by something that happened to you in the service or by something you were exposed to in the service.

**10. What is a "Presumptive Service Connection"?**

This is a presumption in the VA law that says that if a claim is received within one year after separation from active duty it is presumed to have been service connected.

**11. What must I show to get these VA Disability Service Connected benefits?**

What you must show is (1) you currently have a physical and/or mental disability. (2) something happened in the service or shortly after your discharge that you think may be the cause of your current disability. (3) There is a link between what happened in the service and your disability, i.e., the disability is connected to your service.

**12. What if I am injured in a VA facility or program?**

You may also file a claim if your disability or aggravation of your disability is due to medical care received in a VA facility or involvement in a VA vocation rehabilitation program.

**13. What is a "Ratings Schedule"?**

A ratings schedule is primarily a guide for the VA to use and bi percentage increments, it represents an average impairment of earnings capacity from the condition granted. For example, simple tinnitus is a 10% disability. Backs and necks by their nature are more complicated.

**14. What do you mean? I have a bad back and I have trouble bending and walking. How would they try to rate me?**

Back and neck strains are functionally rated based generally on limitation of ranges of motion. The more severe the limitation, the higher the rating. Please note that that VA regulations require ranges of motion to be rounded up to the nearest 5 degrees.

Lumbosacral, or cervical strain, is also rated based on stiffness, aching, and radiation. For example, an ankylosis (the stiffness of a joint due to disease, injury surgical procedure, fusion and immobility of the joints) of the entire spine will result in a rating of 100, as it is generally a freezing of the entire spine, and no one would be considered able to work with such a condition.

A limitation of the mid back or thoracic vertebrae where there is ankylosis of 50 degrees of flexion or cervical with 30 degrees of flexion or less is rated at 40%. The same areas where flexion is better results only in a reduction of flexion of 15 degrees or less results in a 30% disability.

A limitation of your thoracolumbar forward flexion at between 30 and 60 degrees and forward flexion of the cervical spine at between 15 to 30 degrees with various combined reduced ranges of motion, abnormal gait, scoliosis (corkscrewing), reversed lordosis (straightening) or abnormal kyphosis (round back, hunch back, slouching, dowager's hump), yield only a 20%.

Finally, a Vet is eligible for a 10% rating where he has a small limitation in his cervical or thoracolumbar back that causes him/her spasm, guarding or tenderness.

The biggest problem with the back rating is that the "Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes," 38 C.F.R. § 4.71a is hardly ever used.

The second biggest problem with VA back and neck ratings is that Vets are usually taking medication for pain when tested. This skews the results against the disabled veterans. So, if you go in for your Range of Motions tests, refrain from taking pain medications of all kinds prior to your testing.

This section adds additional disability percentages of between 10 to 40% based on the deviation of incapacitating episodes of back pain of between 2 weeks (10%), 2 to 4 weeks (20%), and over 4 weeks (40%). This rating system should not be overlooked. A veteran is well advised to report every episode of being in bed or home ridden and its duration to his/her treating physician and keep a pain diary.

**15. Is "Functional Loss" considered?**

Yes. Functional loss is considered and comes into play in deciding your unemployability where there is a loss or limitation of joints and skin, for example. Similarly, loss and limitation of bones, structures, muscles, adhesions, nerves, atrophy (shrinking), absence of callosity and the presence of fatigue, pain and reduced motion all come into play. So be sure to report all signs and symptoms to your VA doctor or other physician on presentation.

**16. What if I have two evaluations and one is more restrictive than the other?**

The higher rating will govern. This is called "The Benefit of the Doubt" Rule. This rule states that for all things being equal on any material matter the secretary shall give the Veteran the benefit of the doubt when it comes to the interpretation of objective data that is in conflict with each other.

**17. Do you have any suggestions about preparing for my VA range of motion tests?**

Yes. Do not be stoic and do not load up on your pain medication. It would be better to not take it before the test so that you can feel the difficulties you are having with pain and limitation on your range of motion testing. Save your medication for afterwards, after the test. You will need it then and the VA will have gotten an accurate picture of what is actually going on with your back.

**18. Do you have any other hints or suggestions?**

Absolutely. When you are tested and especially when you are being evaluated by the VA or Board physicians, it will be a long day. You will wait and wait and then wait some more. When your test is over, you will literally want to get to your car or ride as quickly

as possible or to get home to lie down or take your medication. Just take it easy. On numerous occasions we have read statements of the case to find that the claimants are being watched as they sit, walk and especially as they leave the VA. Their eagerness to get home to their family and easy chair and to get the hell away of a long day of waiting and pain are uniformly interpreted as signs that the Vets were over-magnifying their symptoms. These observations by your friendly evaluating physician are always written into evaluations. Your desire to get back to your car as early as you can can and will be used against you. So just, please take it easy. They were in no hurry to see you. Don't be in any hurry to get out to your car or parking lot.

**19. Is the VA rating dependent on my condition getting better or worse?**

Not really. Your rating should be based on your entire history, not its waxing and waning. The VA will presume that if there are two conflicting evaluations, they will give you the benefit of the doubt and award you based on the higher evaluation.

**20. How is my "Total Disability Rating" determined?**

Your disability will be considered to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation, and it is reasonably certain to permanently continue throughout the life of the disabled Veteran.

**21. When is "Total Disability" presumed to exist?**

Total disability will be considered to exist when there is present any impairment of mind or body that is sufficient to render it impossible for the average person to follow a substantially gainful occupation throughout his life. This total disability is presumed when a Veteran has lost both feet or hands or combination of two, has bilateral blindness, or is permanently helpless or bedridden.

**22. Well, I understand how if my rating is 100% how I might get a full VA Service connected disability. But how about if my disabilities add up to something less and I still cannot work. What then? Am I out of luck?**

No, fortunately, you are not out of luck. A "Total Disability rating Based on Unemployability" may apply.

**23. What is a rating based on "Unemployability" (TDRU)?**

This rating is used when the schedule of ratings is less than 100% and where the Veteran has been unable to secure or follow a substantially gainful occupation as a result of service connected disabilities.

**24. What is the norm for finding total disability based on unemployability outside of the traditional ratings schedule?**

The norm for such a disability is a finding that the case presents such an exceptional or unusual disability picture with such related factors as marked interference with employment or frequent periods of hospitalization to render impracticable the application of regular scheduled standards.

**25. Ok, so what if I am not 100 percent and I still cannot work. What will the VA look at to see if I am entitled to a full award of disability compensation?**

If you have one single service connected disability that is 60% or more, you should be determined to be disabled and entitled to 100% of your Disability benefits based on unemployability.

**26. What if I do not have a single 60%. Can I still get the full amount based on unemployability?**

Yes. If you have one disability rating of at least 40% and at least one other disability rating or combination of two or more other disability ratings that, when added to the 40%, yield 70% total or more, then you would be entitled to a 100% unemployability rating. You can also get individual unemployability benefits with a 70% rating or less if the VA sends you out for "extra-schedular" consideration of your combined impairments. This is rarely done, so the vet at less than 70% needs to request this consideration in his "IU" claim. He/she also needs to see if all his/er impairments pursuant to 38 C.F.R. 4.21 – 6.1 have been claimed and addressed by the VA.

**27. What if I don't have one 40% rating? Can I still get a full disability award?**

Yes. Some disabilities are combined to get 40%, like one or both upper or lower extremities with consideration of bilateral factors affecting them. Bilateral carpal tunnel or ulnar neuropathy with loss of functional use bilaterally would be such a case.

**28. What about if I parachuted, fell or was injured by an explosive device that injured my back, but also affected my sight or arms or legs? Shouldn't I be eligible for the 40%?**

Yes. A single incident that causes a common etiology may be combined to make an exception to the 40% rule. An example may be a jump, fall or a back injury that occasioned injury to an ankle, knee, hip, low back, upper back, neck and arms that were broken or injured in a fall or attempt to break the fall or injury.

**29. What about other body organs, are they also grouped?**

Yes. Single orthopedic, digestive, respiratory, cardiovascular-renal, neuro-psychiatric symptoms are also combined to surpass the 40% threshold.

**30. What about where I injured numerous body parts and mechanisms in action?**

Yes. Multiple injuries incurred in an action will be grouped together as one to get you past the aggregate 40%.

**31. Are these standards ever set aside for special cases?**

Yes. These standards may be set aside specifically where the evidence clearly and factually shows that the Veteran has been rendered unemployable solely due to service connected disabilities regardless of these individual and combined percentages. In such cases the VA will submit your case to the Director of the Pension service for "extra-schedular" consideration.

**32. Can you give me an example?**

Yes. For example, if you have a low back rating that is over 10% and you have psychiatric problems that keep you form focusing or concentrating on simple one and two step tasks and which would prohibit you from being reliable, punctual and not absent regularly from work. This might be such a case.

**33. What if they say my case is not entitled to such a review?**

You may appeal that determination.

**34. What if my Statement of the Case is silent on this point?**

You should write to the VA and specifically ask for the determination to be made.

**35. What if I work for my family because nobody else will hire me because of my service connected disabilities? Is that "Substantial gainful Employment"?**

It probably is not. "Sheltered employment" is not considered substantial gainful employment. Nor is family employment where it is "marginal."

**36. What do you mean by "Marginal"?**

Marginal employment is not considered to be substantial gainful employment because "Marginal" means that amount which is less than the amount established by the U.S. Department of Commerce, Bureau of the Census as the poverty threshold for one person. It can also mean employment in a protective environment, family business or sheltered workshop when earnings even exceed this poverty threshold.

**37. Is the reason for my leaving employment or termination relevant to my VA claim?**

Yes. 38 U.S.C. 501(a) makes the basis for work cessation or termination relevant. So if you have psychiatric problems and cannot work around or with people and left your job, this would be an adequate reason. If you suffered repetitive trauma to both your hands that made work impossible for you on a regular sustained basis and you had to leave or were released from your work that would also be relevant to your unemployability claim. If you quit your job because you were not making enough or had to move, these reasons would not ordinarily support your claim and may lead one to presume that you were not disabled at the time you last worked.

**38. What if I was working in a "Special Program"?**

Where employment has been provided to the Veteran on account of the disability or with special conditions because of the disability, and the Veteran cannot secure subsequent employment or only intermittent employment or unsuccessful attempts to remain employed, he will be considered to some great measure "unemployable."

**39. When should I file my claim?**

Do not wait to file your claim for Veteran's disability benefits. You can lose benefits if you wait and make proof of your claim more difficult. A dated, handwritten note is enough to start your claim. So file your claim as early as you can to get the earliest possible beginning date for benefits.

**40. Who is responsible for filing information to support my claim for benefits?**

It is the Veteran's responsibility to support his or her claim for benefits. This also includes attendance at physicals and may also entail having to hire your own physician to complete an independent and comprehensive impairment rating for you or your attorney or representative. The physician performing your consultative medical evaluation (CME) is working for the VA. He/she is there for the VA, not for you. His/her opinion will be adversarial. I regularly see CME reports stating that the claimant was observed even walking to his car.

**41. If my claim is denied, when should I file my appeal?**

A denial of benefits must be appealed within time deadlines. Make sure you file your appeal within the deadlines or get a representative to do so. Your substantive appeal must be received within one-year appeal period after your benefits have been denied. There is a sixty-day period for simultaneously contested claims that also runs. See 38 U.S.C.7105(d)(3).

**42. What if I don't file my appeal within the requisite deadlines?**

If you do not file a timely appeal, you may have to start over with the claims process.

**43. What are my rights to appeal a VA decision?**

After a decision has been reached on your VA claim, If the VA was not able to grant some or all of the VA benefits you asked for and you do not agree with the VA decision, you may:
* Appeal to the Board of Veterans' Appeals (the Board) by telling the VA you disagree with the VA's decision.
* Give the VA evidence the VA does not already have that may lead the VA to change its decision.

**44. What is an Appeal to the Board of Veterans' Appeals, (BVA Appeal)?**

An appeal is your formal request that the Board review the evidence in your VA file and review the law that applies to your appeal. The Board can either agree with your decision or change it. The Board can also send your file back to the VA for more processing before the Board makes its decision.

**45. How can I appeal the decision and how do I start my appeal?**

To begin your appeal, write the VA a letter telling the VA you disagree with the VA's decision. This letter is called you "Notice of Disagreement." If the VA denied more than one claim for a benefit (for example, you claimed compensation for three disabilities and the VA denied two of them), please tell the VA in your letter which claims you are appealing. Send your Notice of Disagreement to the address at the top of your VA letter.

**46. When do I file the Notice of Disagreement?**

The Notice of Disagreement must be filed within one-year from the date the VA mails you the Notice of Determination to the claimant, otherwise the agency determination becomes final.

**47. What happens after the VA receives my Notice of Disagreement (NOD)?**

The VA either will grant your claim or if it does not, it will send you a "Statement of the Case." A Statement of the Case describes the facts, laws, regulations, and reasons that the VA used to make their decision. The VA will also send you a VA form 9.

**48. What is a VA Form 9?**

Technically, a VA Form 9 is an "Appeal to Board of Veterans' Appeals." with the Statement of the Case. You must complete this VA Form 9 and return it to the VA if you want to continue your appeal.

**49. That sounds complicated. What do I have to write in my VA Form 9 so that my appeal is accepted?**

In filling out your VA Form 9, you must specifically and clearly set forth: (1) The Benefit Claimed; (2) A clear and concise statement as to the factual and legal basis of your disagreement with the VA's earlier unfavorable determination; (3) Errors the VA made in applying the law.

**50. How long do I have to start my BVA appeal?**

You have one year to appeal the VA's decision. Your letter saying that you disagree with the VA decision must be postmarked (or received by the VA) within one year from the date of the VA's letter denying you the benefit. In most cases, you cannot appeal a decision after this one-year period has ended.

**51. So is timing important?**

Yes, your VA Form 9 is your substantive appeal of the VA's action and must be filed within 60 days of the date placed on the "Statement of the Case" or within 1 year from the mailing date of the notification of the unfavorable VA determination being appealed, whichever is the later date.

**52. What does "Supplemental Statement of the Case" do to my time to appeal?**

The Supplemental Statement of the Case, when furnished to you by the VA, only gives you 30 days to respond. So be careful of this trap. Many Vets think they still have 60 days in which to respond. Unfortunately, it is not so.

**53. How does the VA determine that my appeal has been timely filed?**

The date that you mail your VA 9 form is the date that your appeal is deemed filed.

**54. Do I just send my appeal First Class Mail?**

No. Send it certified mail, return receipt requested, and keep a copy for your records. Things at the VA get lost all the time. The only way you can prove that you timely sent your appeal is with the return receipt and copy of your documents.

**55. What happens if I do not start my appeal on time?**

If you do not start your appeal on time, the VA's decision will become final. Once the VA's decision is final, you cannot get the VA benefit you were denied unless you either:
* show that the VA was clearly wrong to deny the benefit or
* send the VA new evidence that relates to the reason the VA denied your claim

**56. Can I get a hearing with the Board?**

Yes. If you decide to appeal, the Board will give you a hearing if you want one. The VA will send you the VA Form 9with the Statement of the Case that has complete information about the kinds of hearings the Board offers and convenient check boxes for requesting a Board hearing. The Board does not require you to have a hearing. It is your choice. We advise that you request one in most cases. If you are represented, your representative will most likely check that box.

**57. Where can I find out more about appealing to the Board?**

You can find a "plain language" booklet called "How do I Appeal" on the Internet at: www.va.gov/vbs/bva/pamphlet.htm. The booklet may also be requested by writing to Hearings and Transcription Unit (014HRG), Board of Veterans' Appeals, 810 Vermont Avenue NW, Washington DC 20420.

You can find the formal rules for appealing to the Board in the Board's Rules of Practice at title 38, Code of Federal regulations, Part 20. You can find the complete Code of Federal Regulations on the Internet at: www.gpoaccess.gov/crf/index.html. A printed copy of the Code of Federal Regulations may be available at your local law library.

**58. What if I am denied my benefits? Can I get someone to help me with my appeal to the Board?**

Yes. You can have a Veterans' service organization representative, an attorney-at-law, or an "agent" help you with your appeal. But you are not required to have someone represent you. It is your choice. We believe it is best to have independent representation.

**59. Do I have to pay someone to help me with my appeal to the Board?**

It depends on who helps you. The following explains the differences:
*Veterans' service organizations will represent you for free.
*Attorneys or agents can charge you for helping you under some circumstances.

Paying their fees for helping you with your appeal to the Board is your responsibility. If you do hire an attorney or agent to represent you, one of you must send a copy of any fee agreement to the following address within 30 days from the date of agreement is executed: Office of the General Counsel (022D), 810 Vermont Avenue NW, Washington, DC 20420. See 38 C.F.R. 14.636(g). If the fee agreement provides for the direct payment of fees out of past-due benefits, a copy of the agreement must also be filed with us at the address at the top of our letter. See 38 C.F.R. 14.636(h)(4)

**60. Can I get someone to represent me for free?**

Representatives who work for accredited veterans' service organizations know how to prepare and present claims and will represent you. You can find a listing of these organizations on the Internet at: www.va.gov/vso. There is some controversy involving these representatives, as many may be afraid to lose part of their benefits, if they are too zealous a representative on your behalf.

**61. Should I hire an attorney?**

A private attorney or an "agent" can also represent you. If applicable, your local bar association may be able to refer you to an attorney with experience in veterans' law. VA only recognizes attorneys who are licensed to practice in the United States or in one of its territories or possessions. An agent is a person who is not a lawyer, but who the VA recognizes as being knowledgeable about Veterans' law. Contact us or the VA if you would like to know if there is another VA accredited agent in your area.

**62. Can or should I give VA additional evidence?**

Yes. You can send the VA more evidence to support a claim whether or not you appeal to the Board. If you want to appeal, though, do not forget the one-year limit!

**63. When should I give the VA my evidence?**

If you have more evidence to support a claim, it is in your best interest to give the VA that evidence as soon as you can. The VA is supposed to consider your evidence and let you know whether it changes its decision. Please keep in mind that the VA can only consider new evidence that: (1) it has not already seen and (2) relates to your claim. You may give the VA this evidence either in writing or at a personal hearing.

**64. What if I choose to present new evidence?**

In writing to support you claim, you may send documents and written statements to the VA at the address on the top of the VA letter. Tell the VA in a letter how these documents and statements should change the VA's decision.

**65. When can I request my local VA hearing?**

At a personal hearing you may request a local hearing with the VA at any time.

**66. Is the VA hearing separate from my Board (BVA) hearing?**

Yes. This hearing is separate from any Board hearing you might ask for later if you appeal to the BVA. The VA does not require you to have a local hearing. It is your choice. At this local hearing, you may speak, bring witnesses to speak on your behalf, and hand the VA written evidence. If you want a hearing, send the VA a letter asking for a hearing. Use the address at the top of the VA letter. The VA will then:
* Arrange a time and place for the hearing
* Provide a room for the hearing
* Assign someone to hear your evidence
* Make a written record of the hearing.

**67. What happens after I give VA evidence?**

The VA will review the record of the hearing and other new evidence, together with the evidence the VA already has. The VA will then decide if it can grant your claim. If the VA cannot grant your claim and you appeal, the VA will send the new evidence and the record of any local hearing to the Board.

**68. When will my VA check be delivered?**

A check covering the initial amount due under this award will be mailed within 15 days. Thereafter, checks will be delivered at the beginning of each month for the prior month.

**69. What if I get a VA pension because most of my disability was not service connected and my service connected disability increases; can i go from pension to Service connected total disability?**

You may be entitled to Service Connected Disability Benefits. Unemployability for pensions where previously established on the basis for service connected disability and non service connected disability may become a service connected disability when the service connected disabilities have increased in severity.

**70. How can I receive additional benefits for dependents?**

You may be entitled to additional benefits for your unmarried children if the children are under age 18 or under 23 if attending an approved school, or if, prior to age 18, the child has become permanently incapable of self-support because of mental or physical defect. You may contact VA as shown above for information on applying for this benefit.

**71. How can I receive aid and attendance or housebound benefits?**

VA may pay a higher rate of pension to a veteran who is blind, a patient in a nursing home, otherwise needs regular aid and attendance, or is permanently confined to his or her home because of a disability. You may contact the VA as shown above for information on applying for this benefit.

**72. How can I receive Hospitalization and Outpatient Treatment?**

Veterans who are entitled to pension and/or special monthly pension (aid and attendance or housebound benefits) as determined by the Veterans Benefits Administration are eligible for medical care through the VA health care system. If you are interested in obtaining VA medical care, you may contact your nearest VA health care Facility or the VA Health Benefits Service Center at 1-877-222-8387.

**73. How can certain expanses increase my rate of improved pension?**

Family medical expenses and educational and vocational rehabilitation expenses actually paid by you may be used to increase your rate of pension. Family medical expenses are amounts paid by you for medical expenses for yourself and relatives you are under an obligation to support, including premiums paid for health insurance. VA will deduct the amount you paid for medical expenses from you countable income if the expenses qualify for exclusion under the formula provided by law. Educational or vocational rehabilitation expenses are amounts paid for courses of education, including tuition, fees, and materials and may be deducted from the income of a Veteran or the earned income of a child, if the child is pursuing a course of post-secondary education or vocational rehabilitation or training. Keep track of the un-reimbursed amounts you pay. Normally these expenses are reported at the end of the year with an Eligibility Verification Report. Family maintenance (hardship) expense may also be used to increase your rate of pension. VA can exclude all or part of you dependent child's income if it is not reasonably available to you, or if it would cause hardship to consider this income in determining your rate of pension. If VA is not currently excluding your children's income and you feel that it should be, contact the nearest VA office and complete VA Form 21-0571, Application for Exclusion of Children's Income.

**74. How can I receive information about Government Life Insurance?**

If you are paying premiums of Government life insurance (GI insurance) and are unable to work, you may be entitled to certain benefits as provided in your policy. For complete

information about GI Insurance, contact the Department of Veterans Affairs Insurance Center at 1-800-669-8477 or visit the VA website at www.insurance.va.gov.

**75. Are my benefits exempt from claims of creditors?**

VA pension payments are exempt from claims of creditors. With certain exceptions, the payments are not assignable and are not subject to attachment, levy, or seizure except as claim of the United States.

**76. Do I report a change of address?**

Yes. Please notify The Department of Veterans office immediately of any change of address.

**77. What conditions affect my right to payment?**

1. Your rate of pension depends upon the amount of family income and the number of dependents. Your benefits may be affected by any changes in the amount of family income and marital or dependency status of you or your dependents.

A. Change in family income and net worth: You are required to report the total amounts and sources of all income and net worth for you and your dependents from whom you have been awarded benefits. Some income is not countable. If you report such income, VA will exclude it when computing your income for VA purposes. Benefit rates and income limits change frequently; however, you can find out what the current income limitations and rates of benefits are by contacting the VA.

B. Change in marital or dependency status: You or your survivors must notify the VA of any change in marital or dependency status or upon death. Examples of changes in marital or dependency status include the death of a dependent, the marriage of you or your dependent child, and discontinuance of a child's school attendance.

2. Your benefits may be reduced as shown below if you have no dependents and are furnished hospital, VA domiciliary or nursing home care at government expense. If you are receiving the aid and attendance allowance, your rate may also be reduced to the household rate as of the first day of the second calendar month following the month of admission. Benefits at the full rate may be resumed the date of discharge.

Veterans receiving Old Law Pension (pension awarded under the law in effect prior to July 1, 1960): If you have no dependents and are furnished hospital, VA domiciliary or nursing home care at government expense for six months or more, your pension may be reduced to $30.00 or half of the monthly amount payable whichever is greater, as of the

first day of the seventh calendar month following the month of admission. The VA will pay you the withheld amount after an approved discharge by the institution authorities. If the discharge is for disciplinary reasons or against medical advice, the withheld amount will not be paid for six months from the date of discharge. If you are readmitted within six months of a prior period of such are and the prior discharge was not approved, the new period of care is considered a continuation of the previous period. Benefits will be reduced the first day of the seventh calendar month following the prior admission of the date of readmission, whichever is the later date.

Veterans receiving Section 306 Pension (pension awarded under laws in effect from July 1, 1960 and prior to January 1, 1979): If you have no dependents and are furnished hospital, VA domiciliary or nursing home care at government expense your rate of pension may not exceed $50.00 as of the first day of the third calendar month following the month of admission. If you are readmitted for such care within six months of a prior period of care that lasted two or more full calendar months, the rate of pension may not exceed $50.00 as if the date of readmission.

Veterans receiving Improved Pension (pension awarded under laws in effect from January 1, 1979): If you have no dependents and are furnished hospital, VA domiciliary or nursing home care at government expense your rate of pension may not exceed $90.00 as of the first day of the fourth calendar month following the month of admission. If you are readmitted for such care within six months of the prior period of care, your rate of pension may not exceed $90.00 as of the first day of the month following readmission.

3. If your award includes aid and attendance benefits based on nursing home patient status, you must immediately notify the VA when you are no longer a nursing home patient.

4. Your benefits will be discontinued effective the 61st day of incarceration in a Federal, State or local penal institution following conviction for a felony or misdemeanor. Your spouse or dependent children may be entitled to benefits at the death pension rate from the date your benefits are discontinued if a claim is received within one year after we notify you of discontinuance of benefits. Any payments made to your spouse or child will continue until we receive notice that the incarceration has ended.

5. Monthly payments of your award may be stopped if you fail to furnish evidence as requested or if you furnish the VA, or cause to be furnished, any false or fraudulent evidence.

6. Information submitted including income information, is subject to verification through computer matching programs with other agencies.

7. The law provides severe penalties which include fine or imprisonment, or both, for fraudulent acceptance of any payment to which you are not entitled.

Notify the VA immediately if there is a change in any condition affecting your right to continued payments. Failure to notify the VA of these changes immediately will result in an overpayment which is subject to recovery.

**78. If I am receiving VA Disability, should I let my attorney know and give him a copy of my VA Award notice before my case is set or soon after my case is set for hearing?**

Yes. The ALJ will consider a favorable decision by the VA to award you benefits as favorable evidence in your case so make sure you provide SSA with written notification of your VA award letter and percentage of disability or unemployability rating.

**79. If I am a Disability Claimant, as a Veteran who has applied for Social Security Disability or SSI Benefits, must my VA Doctor assist that claimant in completing paperwork helpful to my Social Security Disability or SSI case?**

Yes. According to VA Directive, a claimant's VA Physician is mandated by VA Directive 2008-071 to render assistance to the claimant in completing forms that will assist the claimant in his petition for Social Security Benefits and benefits through other Federal programs.

To view or download a copy of VA Directive 2008-071, click on our website at www.disabilityattorney.net.

**80. If I have more questions concerning VA Awards, where can I find out more information?**

Information concerning Department of Veterans Affairs, Federal, State or local benefits may be obtained form your nearest VA office or any national service organization representative. You may call VA toll-free at 1-800-827-1000.



Tampa Location:
15501 N. Florida Ave
Tampa, FL 33613
813-264-5363

WWW.DISABILITYTTORNEY.NET