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

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

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

In addition, as in the examples of limitations for the other five domains, we consider a child's age [18] in determining whether there is a limitation in functioning in the domain of ''Health and physical well-being.'' 20 CFR 416.926a(1)(4). While it is less likely that age will be a factor in determining whether there is a limitation in this domain, it is still possible, and we must consider the expected level of functioning for a given child's age in determining the severity of a limitation.

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

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

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The ''Whole Child'' Approach; SSR 09–2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Acquiring and Using Information''; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Attending and Completing Tasks''; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Interacting and Relating with Others''; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving About and Manipulating Objects''; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Caring for Yourself''; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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

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

[18] *See* 20 CFR 416.924b.

[FR Doc. E9–3385 Filed 2–13–09; 8:45 am]

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SOCIAL SECURITY ADMINISTRATION

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

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

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

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

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

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

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

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

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

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

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

Dated:

February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

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

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

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

Introduction: A child[1] who applies for Supplemental Security Income (SSI) [2] is ''disabled'' if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments [3] that results in ''marked and severe functional limitations.'' [4] 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of

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

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

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

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

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

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

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

20 CFR 416.926a(b)(1).[7]

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

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

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

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

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

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

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

Policy Interpretation

I. General

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

More specifically, we consider the following questions.

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

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

20 CFR 416.926a(b)(2).

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

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

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

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

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

[6] *See* 20 CFR 416.926a(e) for definitions of the terms ''marked'' and ''extreme.''

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

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

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

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

II. Determining Which Domains Are Involved in Doing Activities

A. General

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

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

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

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

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

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

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

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

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

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

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

A boy in elementary school with attention-deficit/hyperactivity disorder (AD/HD) has trouble with all of the following activities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An adolescent has a diagnosis of borderline intellectual functioning (BIF) and has been a ''slow learner'' throughout school. She also has recently been diagnosed with depression. She has received special education services throughout her school years and is now in the 11th grade. She has attended special classes for all of her academic subjects, but has been mainstreamed for some elective courses and extracurricular activities. Her teacher reports that she performed satisfactorily in most of her classes in previous years, but for the past two semesters has become inattentive in class, has failed three academic subjects because of inattention and failure to complete her assignments, and has frequently refused to go to school. Her mother reports that at home the child cries a lot, sleeps as long as 12 hours every night, eats irregularly, complains of headaches, and is irritable, uncooperative, and angry more often than not. Despite many attempts, the parent has been unable to engage her daughter in talking about what is wrong and how she might help.

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

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

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

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

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

III. Rating Severity

A. General

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

It is important to determine the extent to which an impairment(s) compromises a child's ability to independently initiate, sustain, and complete activities. To do so, we consider the kinds of help or support the child needs in order to function. *See* 20 CFR 416.924a(b). In general, if a child needs a person, medication, treatment, device, or structured, supportive setting to make his functioning possible or to improve the functioning, the child will not be as independent as same-age peers who do not have impairments. Such a child will have a limitation, even if he is functioning well with the help or support.

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

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

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

B. Rating the Severity of Limitations in the Domains

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

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

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

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

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

[16] *See* 20 CFR 416.924a(b)(5).

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

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

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

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

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

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

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

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

IV. Example of a Functional Equivalence Analysis

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

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

A. How does the child function?

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

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

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

The following chart[18] provides a picture of the child's functioning, including information about several factors that are relevant to determining the severity of his limitations; for example, help from a parent and school aide, medications, and play therapy. As shown in the chart, the descriptions from the evidence about how the child functions must be specific, not general. For example, ''the child is anxious'' is a general conclusion, while the notes in the chart below state specifically what the child does and how he does it, based on his own words and the observations of the medical sources and adults who know him and spend the most time with him.

[17] For example, in 20 CFR 416.924a(b)(8), we provide: ''If you have a chronic impairment(s) that is characterized by episodes of exacerbation (worsening) and remission (improvement), we will consider the frequency and severity of your episodes of exacerbation as factors that may be limiting your functioning. Your level of functioning may vary considerably over time. Proper evaluation of your ability to function in any domain requires us to take into account any variations in your level of functioning to determine the impact of your chronic illness on your ability to function over time.'' When we published this rule in 2000, we explained that, while we adopted the language from section 12.00D of the adult mental disorders listings, ''[t]his principle is equally applicable to children and adults, and to both physical and mental impairments.'' *See* 65 FR at 54754.

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

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

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

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

V. Responsibility for Determining Functional Equivalence

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

- For initial and reconsideration determinations, the State agency medical or psychological consultant has the overall responsibility for determining functional equivalence.
- When an SSI recipient has requested a hearing before a disability hearing officer at the reconsideration level, the disability hearing officer determines functional equivalence.
- For cases at the Administrative Law Judge (ALJ) and Appeals Council (AC) levels (when the AC makes a decision), the ALJ or AC determines functional equivalence. 20 CFR 416.926a(n).

While SSR 96–6p[20] requires that an ALJ or the AC must obtain an updated medical expert opinion before making a decision of disability based on *medical* equivalence, there is no such requirement for decisions of disability based on *functional* equivalence. Therefore, ALJs and the AC (when the AC makes a decision) are not required to obtain updated medical expert opinions when they determine that a child's impairment(s) functionally equals the listings.[21]

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

Cross-References: SSR 09–2p, Title: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Acquiring and Using Information''; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Attending and Completing Tasks''; SSR 09–5p, Title XVI: Determining Childhood Disability—''Interacting and Relating with Others''; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving About and Manipulating Objects''; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Caring for Yourself''; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''; SSR 98–1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; SSR 96–6p, Titles II and XVI: Consideration of Administrative Findings of Fact by State Agency Medical and Psychological Consultants and Other Program Physicians and Psychologists at the Administrative Law Judge and Appeals Council Levels of Administrative Review; Medical Equivalence; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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

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

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