

MEDICAL REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

FO CODE:

The individual named below has filed an application for a period of disability and/or disability payments. If you complete this form, your patient may be able to receive early payments. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)," attached.

I hereby authorize the medical source named below to release or disclose to the Social Security Administration or State agency any medical records or other information regarding the child's treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S PARENT'S OR GUARDIAN'S SIGNATURE (Required only if Form SSA-827 is NOT attached) DATE

A. IDENTIFYING INFORMATION

CLAIMANT'S NAME	CLAIMANT'S SSN	CLAIMANT'S PHONE NUMBER
CLAIMANT'S ADDRESS	CLAIMANT'S DATE OF BIRTH	MEDICAL SOURCE'S NAME

B. HOW WAS HIV INFECTION DIAGNOSED?

Laboratory testing confirming HIV infection Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. CONDITIONS RELATED TO HIV INFECTION: Please check if applicable.

ALL INFORMATION PROVIDED IN THIS SECTION MUST BE SUPPORTED BY DOCUMENTATION IN THE MEDICAL RECORD. We will request your patient's medical records as part of our case adjudication process.

1. Multicentric (not localized or unicentric) Castleman disease

Affecting multiple groups of lymph nodes
 Affecting organs containing lymphoid tissue

2. Primary central nervous system lymphoma

3. Primary effusion lymphoma

4. Progressive multifocal leukoencephalopathy

5. Pulmonary Kaposi sarcoma

6. CD4 Count: Please indicate measurement, date recorded, AND ordering provider

a. Birth to attainment of age 1:

Absolute CD4 count of 500 cells/mm³ or less
 CD4 percentage of less than 15 percent

b. Age 1 to attainment of age 5:

Absolute CD4 count of 200 cells/mm³ or less
 CD4 percentage of less than 15 percent

c. Age 5 to attainment of age 18:

Absolute CD4 count of 50 cells/mm³ or less

**SSA-4815
MEDICAL REPORT
ON CHILD WITH
ALLEGATION OF
HIV INFECTION**

**B. How Was HIV
Infection Diagnosed?**

Medical source to check appropriate box to indicate the manner in which HIV Infection was diagnosed

**C. Conditions Related
To HIV Infection**

1-5) Medical source to check appropriate box(es) if applicant has any of the listed conditions

6a) Medical source to check box to mark applicant's CD4 Count from birth to attainment of age 1

6b) Medical source to check box to mark applicant's CD4 Count from age 1 to age 5

6c) Medical source to check box to mark applicant's CD4 count from age 5 to age 18

**Medical Release
Information:**

Check first box if Form SSA-827 is attached to Form SSA-4815

Check second box to authorize release of medical records related to HIV infection

Have applicant's parent or legal guardian sign and date if there is no signed Form SSA-827

A. Identifying Information

Write in applicant's full name, Social Security Number, telephone number, mailing address and date of birth in the first five boxes. Write in the medical source's name in the sixth box in this section

Conditions Related To HIV Infection (continued)

7) Medical source to write in any complication(s) the applicant experienced requiring at least three hospitalizations within a 12-month period at least 30 days apart

Medical source to write in the complication(s), date(s) of hospitalization, duration of hospitalization(s) and names of hospital(s)

9a) Medical source to write in applicant's CD4 count from birth to attainment of age 5 as well as from age 5 to attainment of age 18

7. **Complication(s) of HIV infection requiring at least three hospitalizations within a 12-month period and at least 30 days apart.** Each hospitalization must last at least 48 hours, including hours in a hospital emergency department immediately before the hospitalization. Complications of HIV infection may include infections (common or opportunistic), cancers, and other conditions.

Complication of HIV Infection	Date of Hospitalization	Duration	Name of Hospital
Example: Diarrhea	Example: December 2, 2015	Example: 2 days	Example: Memorial Hospital

8. **Neurological manifestation of HIV infection** including, but not limited to, HIV encephalopathy or peripheral neuropathy, resulting in one of the following specified impairments. **Either both a and b or a and c are required.**

a. **Neurological manifestation** (please specify):

Resulting in b. or c.

b. *Each of these items requires two examinations at least 60 days apart. You must check the appropriate impairment and fill out the table indicating the dates of examination*

- Loss of previously acquired developmental milestones or intellectual ability (including the sudden onset of a new learning disability), documented on two examinations at least 60 days apart
- Progressive motor dysfunction affecting gait and station or fine and gross motor skills, documented on two examinations at least 60 days apart
- Microcephaly with head circumference that is less than the third percentile for age, documented on two examinations at least 60 days apart

DATE OF EXAMINATION	DETAILS (if applicable)	PROVIDER (if other than the person completing form)

OR

c. Brain atrophy, documented by appropriate medically acceptable imaging

DATE OF IMAGING	DETAILS (if applicable)	IMAGING CENTER

9. **Immune suppression and growth failure.** Both a and b are required.

a. **CD4 count:**

From birth to attainment of age 5, CD4 percentage of less than 20 percent
Please indicate measurement, date recorded, AND ordering provider

From age 5 to attainment of age 18, absolute CD4 count of less than 200 cells/mm³ or CD4 percentage of less than 14 percent. Please indicate measurement, date recorded, AND ordering provider

8a) Medical source to write in any neurological manifestation experienced by the applicant,

and

8b) Medical source to check appropriate box relating to neurological manifestation and write in the dates, details and providers of the examinations,

or

8c) Medical source to write in the date, details, and imaging center if applicant has experienced brain atrophy

Conditions Related to HIV Infection (continued)

9b) Top Chart - for applicants from birth to attainment of age 2, medical source to write in growth failure in three weight-to-length measurements according to specified time periods. See charts on pages 6-7, if needed

Bottom Chart – for applicants age 2 to attainment of age 18, medical source to write in growth failure in three BMI-for-age measurements according to specified time periods. See charts on pages 8-9, if needed

b. Growth failure:

For children from birth to attainment of age 2, three weight-for-length measurements that are:

- Within a consecutive 12-month period; and
- At least 60 days apart; and
- Less than the third percentile on the appropriate weight-for-length table on pages 6-7.

DATE	LENGTH (cm)	WEIGHT (kg)

For children age 2 to attainment of age 18, three BMI-for-age measurements that are:

- Within a consecutive 12-month period; and
- At least 60 days apart; and
- Less than the third percentile on the appropriate BMI-for-age table on pages 8-9.

DATE	AGE (years and months)	BMI

D. REMARKS: (Please use this space to provide any other comments you wish about your patient.)

E. MEDICAL SOURCE'S NAME AND ADDRESS (Print or type)

	TELEPHONE NUMBER (Include Area Code)
	DATE

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false statement about a material fact in this information, or causes someone else to do so, commits a crime and may be subject to a fine or imprisonment.

F. SIGNATURE AND TITLE (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

FOR OFFICIAL USE ONLY

FIELD OFFICE DISPOSITION:

DISABILITY DETERMINATION SERVICES DISPOSITION:

D. Remarks

Medical source to write any additional information that may be relevant to the applicant's HIV infection

E. Medical Source's Name And Address

Medical source to write in their name, address, telephone number and the current date in the appropriate box

F. Signature And Title Of Person Completing The Form

Medical source to sign name and indicate their professional title

**MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4815
(Medical Report On Child With Allegation Of Human Immunodeficiency Virus (HIV) Infection)**

A claim has been filed for your patient, identified in section A of the attached form, for Supplemental Security Income disability payments based on HIV infection. **MEDICAL SOURCE:** Please detach this instruction sheet and use it to complete the attached form.

1. PURPOSE OF THIS FORM:

IF YOU COMPLETE AND RETURN THE ATTACHED FORM PROMPTLY, YOUR PATIENT MAY BE ABLE TO RECEIVE PAYMENTS WHILE WE ARE PROCESSING HIS OR HER CLAIM FOR ONGOING DISABILITY PAYMENTS. This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Determination Services will contact you later to obtain further evidence needed to process your patient's claim.

2. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

3. MEDICAL RELEASE:

An SSA medical release (an SSA-827) signed by your patient's parent or guardian should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient's parent or guardian.

4. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient's parent or guardian and section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS COMPLETE SECTION B.**
- **COMPLETE SECTION C, IF APPROPRIATE.** If you complete at least one of the items in section C, go to section D.
- **COMPLETE SECTION D IF YOU WISH TO PROVIDE COMMENTS ON YOUR PATIENT'S CONDITION(S).**
- **ALWAYS COMPLETE SECTIONS E AND F.** **Note:** This form is not complete until it is signed.

5. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form, as soon as possible, in the return envelope provided.
- If you received the form from your patient without a return envelope, give the completed, signed form back to your patient's parent or guardian for return to the SSA field office.

Privacy Act Statement Collection and Use of Personal Information

Sections 1614(a)(3), 1631(a)(4), 1631(e)(1), and 1633 of the Social Security Act, as amended, allow us to collect this information. We will use the information you provide to make a determination on the named individual's disability claim.

Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from making an accurate and timely decision on the claim. We rarely use the information you supply for any purpose other than what we state above, however, we may use the information for the administration of our programs, including sharing information:

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,
2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

A list of when we may share your information with others, called routine uses, is available in our Privacy Act System of Records Notices, 60-0103, entitled Supplemental Security Income Record, and Special Veterans Benefits, and 60-0320, entitled Electronic Disability (eDIB) Claim File. Additional information about these and other system of records notices and our programs is available from our Internet website at www.socialsecurity.gov or at your local Social Security office.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the [Paperwork Reduction Act of 1995](#). You do not need to answer these questions unless we display a valid Office of Management and Budget (OMB) control number. The OMB control number for this collection is 0960-0500. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions. *Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

Table 1 - Males Birth to Attainment of Age 2 - Third Percentile Values for Weight-for-Length

Length (Centimeters)	Weight (Kilograms)	Length (Centimeters)	Weight (Kilograms)
45.0	1.597	74.5	8.301
45.5	1.703	75.5	8.507
46.5	1.919	76.5	8.710
47.5	2.139	77.5	8.913
48.5	2.364	78.5	9.113
49.5	2.592	79.5	9.313
50.5	2.824	80.5	9.512
51.5	3.058	81.5	9.710
52.5	3.294	82.5	9.907
53.5	3.532	83.5	10.104
54.5	3.771	84.5	10.301
55.5	4.010	85.5	10.499
56.5	4.250	86.5	10.696
57.5	4.489	87.5	10.895
58.5	4.728	88.5	11.095
59.5	4.968	89.5	11.296
60.5	5.203	90.5	11.498
61.5	5.438	91.5	11.703
62.5	5.671	92.5	11.910
63.5	5.903	93.5	12.119
64.5	6.132	94.5	12.331
65.5	6.359	95.5	12.546
66.5	6.584	96.5	12.764
67.5	6.807	97.5	12.987
68.5	7.027	98.5	13.213
69.5	7.245	99.5	13.443
70.5	7.461	100.5	13.678
71.5	7.674	101.5	13.918
72.5	7.885	102.5	14.163
73.5	8.094	103.5	14.413

Table 2 - Females Birth to Attainment of Age 2 - Third Percentile Values for Weight-for-Length

Length (Centimeters)	Weight (Kilograms)	Length (Centimeters)	Weight (Kilograms)
45.0	1.613	74.5	8.075
45.5	1.724	75.5	8.277
46.5	1.946	76.5	8.479
47.5	2.171	77.5	8.679
48.5	2.397	78.5	8.879
49.5	2.624	79.5	9.078
50.5	2.852	80.5	9.277
51.5	3.081	81.5	9.476
52.5	3.310	82.5	9.674
53.5	3.538	83.5	9.872
54.5	3.767	84.5	10.071
55.5	3.994	85.5	10.270
56.5	4.220	86.5	10.469
56.5	4.220	86.5	10.469
57.5	4.445	87.5	10.670
58.5	4.669	88.5	10.871
59.5	4.892	89.5	11.074
60.5	5.113	90.5	11.278
61.5	5.333	91.5	11.484
62.5	5.552	92.5	11.691
63.5	5.769	93.5	11.901
64.5	5.985	94.5	12.112
65.5	6.200	95.5	12.326
66.5	6.413	96.5	12.541
67.5	6.625	97.5	12.760
68.5	6.836	98.5	12.981
69.5	7.046	99.5	13.205
70.5	7.254	100.5	13.431
71.5	7.461	101.5	13.661
72.5	7.667	102.5	13.895
73.5	7.871	103.5	14.132

Table 3 - Males Age 2 to Attainment of Age 18 - Third Percentile Values for BMI-for-Age

Age (Yrs. and Mos.)	BMI	Age (Yrs. and Mos.)	BMI
2.0 to 2.1	14.5	13.1 to 13.2	15.2
2.2 to 2.4	14.4	13.3 to 13.4	15.3
2.5 to 2.7	14.3	13.5 to 13.7	15.4
2.8 to 2.11	14.2	13.8 to 13.9	15.5
3.0 to 3.2	14.1	13.10 to 13.11	15.6
3.3 to 3.6	14.0	14.0 to 14.1	15.7
3.7 to 3.11	13.9	14.2 to 14.4	15.8
4.0 to 4.5	13.8	14.5 to 14.6	15.9
4.6 to 5.0	13.7	14.7 to 14.8	16.0
5.1 to 6.0	13.6	14.9 to 14.10	16.1
6.1 to 7.6	13.5	14.11 to 15.0	16.2
7.7 to 8.6	13.6	15.1 to 15.3	16.3
8.7 to 9.1	13.7	15.4 to 15.5	16.4
9.2 to 9.6	13.8	15.6 to 15.7	16.5
9.7 to 9.11	13.9	15.8 to 15.9	16.6
10.0 to 10.3	14.0	15.10 to 15.11	16.7
10.4 to 10.7	14.1	16.0 to 16.1	16.8
10.8 to 10.10	14.2	16.2 to 16.3	16.9
10.11 to 11.2	14.3	16.4 to 16.5	17.0
11.3 to 11.5	14.4	16.6 to 16.8	17.1
11.6 to 11.8	14.5	16.9 to 16.10	17.2
11.9 to 11.11	14.6	16.11 to 17.0	17.3
12.0 to 12.1	14.7	17.1 to 17.2	17.4
12.2 to 12.4	14.8	17.3 to 17.5	17.5
12.5 to 12.7	14.9	17.6 to 17.7	17.6
12.8 to 12.9	15.0	17.8 to 17.9	17.7
12.10 to 13.0	15.1	17.10 to 17.11	17.8

Table 4 - Females Age 2 to Attainment of Age 18 - Third Percentile Values for BMI-for-Age

Age (Yrs. and Mos.)	BMI	Age (Yrs. and Mos.)	BMI
2.0 to 2.2	14.1	12.5 to 12.6	14.7
2.3 to 2.6	14.0	12.7 to 12.9	14.8
2.7 to 2.10	13.9	12.10 to 12.11	14.9
2.11 to 3.2	13.8	13.0 to 13.2	15.0
3.3 to 3.6	13.7	13.3 to 13.4	15.1
3.7 to 3.11	13.6	13.5 to 13.7	15.2
4.0 to 4.4	13.5	13.8 to 13.9	15.3
4.5 to 4.11	13.4	13.10 to 14.0	15.4
5.0 to 5.9	13.3	14.1 to 14.2	15.5
5.10 to 7.6	13.2	14.3 to 14.5	15.6
7.7 to 8.4	13.3	14.6 to 14.7	15.7
8.5 to 8.10	13.4	14.8 to 14.9	15.8
8.11 to 9.3	13.5	14.10 to 15.0	15.9
9.4 to 9.8	13.6	15.1 to 15.2	16.0
9.9 to 10.0	13.7	15.3 to 15.5	16.1
10.1 to 10.4	13.8	15.6 to 15.7	16.2
10.5 to 10.7	13.9	15.8 to 15.10	16.3
10.8 to 10.10	14.0	15.11 to 16.0	16.4
10.11 to 11.2	14.1	16.1 to 16.3	16.5
11.3 to 11.5	14.2	16.4 to 16.6	16.6
11.6 to 11.7	14.3	16.7 to 16.9	16.7
11.8 to 11.10	14.4	16.10 to 17.0	16.8
11.11 to 12.1	14.5	17.1 to 17.3	16.9
12.2 to 12.4	14.6	17.4 to 17.7	17.0
		17.8 to 17.11	17.1