



6416 Dean's Hill Road  
Berrien Center, Michigan 49102-9705  
Telephone (616) 471-7741

REPORT TO DISABILITY DETERMINATION SERVICE

Claimant: Larry R. Hale  
S. S. #: 368-66-2961  
Examiner: Dr. Carol Martin, Fully Licensed Psychologist  
Date of Testing: October 31, 1989

Claimant was given an intelligence test on October 31, 1989. Claimant completed the tenth grade in special education at Lakeshore High School. He quit school in 1976. In the last couple of years, he has learned that he has had a heart murmur, but he indicated no other physical problems. He is on Isordil, a medication for his heart rate. He did not bring the medication with him. He had several teeth missing.

He has one sister who is younger. His father is deceased, but he could not remember the year in which this occurred. The mother lives in Stevensville, and he lives with his mother. He has been married three times and will be married shortly for the fourth time. He has had no children with the previous marriages.

He has been employed in lift-truck driving, roofing, and washing and preparing cars for Siemens car dealership. He last worked in Arkansas at a chicken plant killing chickens. He had problems there, he noticed, with his heart. He is unemployed at the present time. He sees Dr. Rambo in Bridgman, who stated, according to the patient, that he cannot work until further tests have been performed on his heart.

He obtained a divorce yesterday. He moved back to Michigan to live with his mother and plans to be married in a few weeks. He states that he has never been arrested. He has a driver's license. He states that he has math and spelling problems. He cannot manage his own funds and has to take his girlfriend with him to the store. Generally he did not seem to be a motivated individual.

The Wechsler Adult Intelligence Scale test was administered. His scaled scores are as follows:

Information:	DISCLOSED BY MICHIGAN DDS TO:
Comprehension:	7
Arithmetic:	9
Similarities:	5
Digit Span:	6
Vocabulary:	12 VRS
Digit Symbol:	7
Picture Completion:	10
Block Design:	7 Other

FAMILY PRACTICE . INTERNAL MEDICINE . OBSTETRICS/GYNECOLOGY/INFERTILITY . PEDIATRICS . SURGERY

Claimant: Larry R. Hale  
Page 2  
Date of Testing: October 31, 1989

Picture Arrangement: 9  
Object Assembly: 7

His Verbal Intelligence score is 73, his Performance Intelligence score is 88, and his Full-Scale Intelligence score is 78, which places him in the borderline range of intelligence with 6.7 percent of the population. His only scores in the average and low-average ranges were for picture completion and picture arrangement. All of his other scores were below average. His lowest score was in arithmetic. He did not seem particularly motivated during the testing and does not seem to have a very high intelligence level to understand everyday and common sense activities from an academic viewpoint.

*Dr. Carol Ann Martin*

Dr. Carol Ann Martin  
Fully Licensed Psychologist  
Southwestern Medical Clinic  
5675 Fairview Avenue  
Stevensville, MI 49127

DISCLOSED BY MICHIGAN DDS TO:

SA: Committed date initial

VMS date initial

Other date initial

CAM:rel

## PSYCHIATRIC REVIEW TECHNIQUE

Name	LARRY R. HALE	SSN	368-66-2961
Assessment is For:	<input checked="" type="checkbox"/> Current Evaluation <i>[7AID FAID]</i> <input type="checkbox"/> 12 Mo. After Onset: _____		
<input type="checkbox"/> Date Last Insured:	<input type="checkbox"/> Other: _____ to _____		
Reviewer's Signature:	K. J. KOBES, D.O.		
MAR. 5 1980			

**PRIVACY ACT NOTICE:** The information requested on this form is authorized by section 223 and section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Completion of this form is mandatory in disability claims involving mental impairments. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

### I. MEDICAL SUMMARY

A. Medical Disposition(s):

1.  No Medically Determinable Impairment
2.  Impairment(s) Not Severe
3.  Meets Listing \_\_\_\_\_ (Cite Listing and subsection)
4.  Equals Listing \_\_\_\_\_ (Cite Listing and subsection)
5.  Impairment Severe But Not Expected to Last 12 Months
6.  RFC Assessment Necessary (i.e., a severe impairment is present which does not meet or equal a listed impairment)
7.  Referral to Another Medical Specialty (necessary when there is a coexisting nonmental impairment)  
(Except for OHA reviewers)
8.  Insufficient Medical Evidence (i.e., a programmatic documentation deficiency is present)  
(Except for OHA reviewers)

B. Category(ies) Upon Which the Medical Disposition(s) is Based:

1.  12.02 Organic Mental Disorders
2.  12.03 Schizophrenic, Paranoid and other Psychotic Disorders
3.  12.04 Affective Disorders
4.  12.05 Mental Retardation and Autism
5.  12.06 Anxiety Related Disorders
6.  12.07 Somatoform Disorders
7.  12.08 Personality Disorders
8.  12.09 Substance Addiction Disorders

- 
- II. REVIEWER'S NOTES (Except OHA reviewers. OHA reviewers should record the subject information in the body and findings of their decision.):** A. Record below the pertinent signs, symptoms, findings, functional limitations, and the effects of treatment contained in the case, B. Remarks (any information the reviewer may wish to communicate which is not covered elsewhere in the form, e.g., duration situations).

DOB = 7/10/58 = 32 yr old.

ADD = ?? 88

DLW = 5/15/87

10<sup>th</sup> grade - spec. ed. from 3<sup>rd</sup> grade → 10<sup>th</sup> (174)

WORK 76-79  
9/87-10/88

EOD = 5/15/87 (DLW).

**III. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER (COMMENT ON EACH BROAD CATEGORY OF DISORDER.)**

**A. 12.02 Organic Mental Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Psychological or behavioral abnormalities associated with a dysfunction of the brain . . . as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Disorientation to time and place
2.    Memory impairment
3.    Perceptual or thinking disturbances
4.    Change in personality
5.    Disturbance in mood
6.    Emotional lability and impairment in impulse control
7.    Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.
8.    Other \_\_\_\_\_

**B. 12.03 Schizophrenic, Paranoid and other Psychotic Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Psychotic features and deterioration that are persistent (continuous or intermittent), as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Delusions or hallucinations
2.    Catatonic or other grossly disorganized behavior
3.    Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
  - a.  Blunt affect, or
  - b.  Flat affect, or
  - c.  Inappropriate affect
4.    Emotional withdrawal and/or isolation
5.    Other \_\_\_\_\_

**C. 12.04 Affective Disorders**

II.

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Depressive syndrome characterized by at least four of the following:
  - a.  Anhedonia or pervasive loss of interest in almost all activities, or
  - b.  Appetite disturbance with change in weight, or
  - c.  Sleep disturbance, or
  - d.  Psychomotor agitation or retardation, or
  - e.  Decreased energy, or
  - f.  Feelings of guilt or worthlessness, or
  - g.  Difficulty concentrating or thinking, or
  - h.  Thoughts of suicide, or
  - i.  Hallucinations, delusions or paranoid thinking
2.    Manic syndrome characterized by at least three of the following:
  - a.  Hyperactivity, or
  - b.  Pressures of speech, or
  - c.  Flight of ideas, or
  - d.  Inflated self-esteem, or
  - e.  Decreased need for sleep, or
  - f.  Easy distractability, or
  - g.  Involvement in activities that have a high probability of painful consequences which are not recognized, or
  - h.  Hallucinations, delusions or paranoid thinking
3.    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)
4.    Other \_\_\_\_\_

**D. 12.05 Mental Retardation and Autism**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22), or pervasive developmental disorder characterized by social and significant communicative deficits originating in the developmental period, as evidenced by at least one of the following:

## PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1.    Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded\*
2.    A valid verbal, performance, or full scale I.Q. of 59 or less\*
3.    A valid verbal, performance, or full scale I.Q. of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function\*
4.    A valid verbal, performance, or full scale I.Q. of 60 to 69 inclusive or in the case of autism, gross deficits of social and communicative skills\*
5.    Other V = 73 PIQ = 88 FSIQ = 78

\*NOTE: Items 1, 2, 3, and 4 correspond to Levels 1, 0.5, 0.25, and 0.00, respectively.

*Borderline Intellectual Function*

**E. 12.06 Anxiety Related Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Anxiety as the predominant disturbance or anxiety experienced in the attempt to master symptoms, as evidenced by at least one of the following:

## PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1.    Generalized persistent anxiety accompanied by three of the following:
  - a.  Motor tension, or
  - b.  Autonomic hyperactivity, or
  - c.  Apprehensive expectation, or
  - d.  Vigilance and scanning
2.    A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity, or situation
3.    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
4.    Recurrent obsessions or compulsions which are a source of marked distress
5.    Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress
6.    Other \_\_\_\_\_

**F. 12.07 Somatoform Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    A history of multiple physical symptoms 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
2.    Persistent nonorganic disturbance of one of the following:
  - a.  Vision, or
  - b.  Speech, or
  - c.  Hearing, or
  - d.  Use of a limb, or
  - e.  Movement and its control (e.g., coordination disturbances, psychogenic seizures, akinesthesia, dyskinesia), or
  - f.  Sensation (e.g., diminished or heightened)
3.    Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury
4.    Other \_\_\_\_\_

**G. 12.08 Personality Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Inflexible and maladaptive personality traits which cause either significant impairment in social or occupational functioning or subjective distress, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Seclusiveness or autistic thinking
2.    Pathologically inappropriate suspiciousness or hostility
3.    Oddities of thought, perception, speech and behavior
4.    Persistent disturbances of mood or affect
5.    Pathological dependence, passivity, or aggressivity
6.    Intense and unstable interpersonal relationships and impulsive and damaging behavior
7.    Other Y.C.E. Mixed Personality Disorder  
(Dependent - Avoidant)

**H. 12.09 Substance Addiction Disorders:** Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

Present — Absent — Insufficient Evidence

If present, evaluate under one or more of the most closely applicable listings:

1.  Listing 12.02—Organic mental disorders\*
2.  Listing 12.04—Affective disorders\*
3.  Listing 12.06—Anxiety disorders\*
4.  Listing 12.08—Personality disorders\*
5.  Listing 11.14—Peripheral neuropathies\*
6.  Listing 5.05—Liver damage\*
7.  Listing 5.04—Gastritis\*
8.  Listing 5.08—Pancreatitis\*
9.  Listing 11.02 or 11.03—Seizures\*
10.  Other \_\_\_\_\_

\*NOTE: Items 1, 2, 3, 4, 5, 6, 7, 8, and 9 correspond to Listings 12.09A, 12.09B, 12.09C, 12.09D, 12.09E, 12.09F, 12.09G, 12.09H, and 12.09I, respectively. If items 1, 2, 3, or 4 are checked, only the numbered items in subsections IIIA, IIIC, IIIE, or IIIG of the form need be checked. The first two blocks under the disorder heading in those subsections need not be checked.

**IV. RATING OF IMPAIRMENT SEVERITY****A. "B" Criteria of the Listings**

Indicate to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04 and 12.06-12.08 and paragraph D of 12.05) exist as a result of the individual's mental disorders.

NOTE: Items 3 and 4 below are more than measures of frequency. Describe in part II of this form (Reviewer's Notes) the duration and effects of the deficiencies (item 3) or episodes (item 4). Please read carefully the instructions for the completion of this section.

Specify the listing(s) (i.e., 12.02 through 12.09) under which the items below are being rated: 12, 05, 12, 08.

FUNCTIONAL LIMITATION	DEGREE OF LIMITATION					Insufficient Evidence <input type="checkbox"/>
	None <input type="checkbox"/>	Slight <input type="checkbox"/>	Moderate <input checked="" type="checkbox"/>	Marked* <input type="checkbox"/>	Extreme <input type="checkbox"/>	
1. Restriction of Activities of Daily Living						
2. Difficulties in Maintaining Social Functioning						
3. Deficiencies of Concentration, Persistence or Pace Resulting in Failure to Complete Tasks in a Timely Manner (in work settings or elsewhere)	Never <input type="checkbox"/>	Seldom <input type="checkbox"/>	Often <input checked="" type="checkbox"/>	Frequent* <input type="checkbox"/>	Constant <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
4. Episodes of Deterioration or Decompensation in Work or Work-Like Settings Which Cause the Individual to Withdraw from that Situation or to Experience Exacerbation of Signs and Symptoms (which may Include Deterioration of Adaptive Behaviors)	Never <input type="checkbox"/>		Once or Twice <input type="checkbox"/>	Repeated* (three or more) <input type="checkbox"/>	Continual <input type="checkbox"/>	Insufficient Evidence <input checked="" type="checkbox"/>

**B. Summary of Functional Limitation Rating for "B" Criteria**

Indicate the number of the above functional limitations manifested at the degree of limitation that satisfies the listings. 0 (The number in the box must be at least 2 to satisfy the requirements of paragraph B in Listings 12.02, 12.03, 12.04, and 12.06 and paragraph D in 12.05; and at least 3 to satisfy the requirements in paragraph B in Listings 12.07 and 12.08.)

\*Degree of limitation that satisfies the Listings; Extreme, Frequent and Continual also satisfy this requirement.

C. "C" Criteria of the Listings

1. If 12.03 Disorder (Schizophrenic, etc.) and in Full or Partial Remission

NOTE: Item b. below is more than a measure of frequency. Describe in part II of this form (Reviewer's Notes) the duration and effects of the episodes. Please read carefully the instructions for the completion of this section.

Present    Absent    Insufficient  
Evidence

a.           

Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of 12.03, although these symptoms or signs are currently attenuated by medication or psychosocial support.

b.           

Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from the situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors).

c.           

Documented current history of two or more years of inability to function outside of a highly supportive living situation.

(For the requirements in paragraph C of 12.03 to be satisfied, either a. and b. or a. and c. must be checked as present.)

2. If 12.06 Disorder (Anxiety Related)

Present    Absent    Insufficient  
Evidence

      

Symptoms resulting in complete inability to function independently outside the area of one's home.

(If present is checked, the requirements in paragraph C of 12.06 are satisfied.)

## **MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT**

九九四三

LARRY R. HALE

SOCIAL SECURITY NUMBER

368.66.2961

**CATEGORIES (From 15 of the PRTF)**

ASSESSMENT IS FOR

### Current Evaluation

12 Months After Onset:

17.05

Date Last  
Instructed:

— 1850-1860 —

Other: \_\_\_\_\_

1

17.08

1

1

1200

## I. SUMMARY CONCLUSIONS

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 is checked for any of the following items, you MUST specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but DO NOT COMPLETE SECTION III.

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Rateable on Available Evidence
<b>A. UNDERSTANDING AND MEMORY</b>					
1. The ability to remember locations and work-like procedures.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
3. The ability to understand and remember detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input checked="" type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>B. SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
4. The ability to carry out very short and simple instructions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
5. The ability to carry out detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input checked="" type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
6. The ability to maintain attention and concentration for extended periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input checked="" type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
8. The ability to sustain an ordinary routine without special supervision.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
9. The ability to work in coordination with or proximity to others without being distracted by them.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
10. The ability to make simple work-related decisions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Rateable on Available Evidence
<b>Continued—SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input checked="" type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>C. SOCIAL INTERACTION</b>					
12. The ability to interact appropriately with the general public.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
13. The ability to ask simple questions or request assistance.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>D. ADAPTATION</b>					
17. The ability to respond appropriately to changes in the work setting.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
18. The ability to be aware of normal hazards and take appropriate precautions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
19. The ability to travel in unfamiliar places or use public transportation.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
20. The ability to set realistic goals or make plans independently of others.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input checked="" type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>B. REMARKS:</b> If you checked box 5 for any of the preceding items or if any other documentation deficiencies were identified, you MUST specify what additional documentation is needed. Cite the item number(s), as well as any other specific deficiency, and indicate the development to be undertaken.					
□ Continued on Page 3					
Form SSA-4734-F4-SUP (Rev. 2-88)	2				

Continued on Page 4

### III. FUNCTIONAL CAPACITY ASSESSMENT

Record in this section the elaborations on the preceding capacities. Complete this section ONLY after the SUMMARY CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form. Include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

Client would have trouble comprehending most instructions, even simple ones, & would not be able to repeat written directions.  
D. resulted in prescriber which reduces his concentration.

Client has wanted pre-emptive action which would prevent him from being able to complete tasks his client was due. This is done as productivity restricted & would not be able to keep up with work load expectation. Quality of work output poor.

to keep up with us. But tends to fit oxygen & carburetors when he comes in.

Client has had improved sleep patterns / better  
interpersonal relationships. Conversely family members / friends  
claim her mood improved. □

MEDICAL CONSULTANT'S SIGNATURE *Clint does* Not possess the RFC's

DATE 4-5-1980

SSA-4734-E4-SUP 1-11

## DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION DOS CDO DRB DOB INTRO	2. DOB CODE 234	3. FILING DATE 08/25/89	4. SSN 368-66-2961	5. SC IF CDB OR DWB CLAIM					
6. NAME AND ADDRESS OF CLAIMANT (Include ZIP Code)									
Mr. Larry R. Hale 7292 Red Arrow Hwy									
Stevensville MI 49127 Berrien County									
7. DATE OF BIRTH 02/10/1958	8. PRODUCTION PD <input type="checkbox"/> PT <input type="checkbox"/>	9. DISTRICT-BRANCH OFFICE ADDRESS (Include ZIP Code) 225 Colfax Ave. Benton Harbor MI 49022 Offc Phone: (616) 926-8535							
10. DATE 08/28/89	11A. Presumptive Disability <input type="checkbox"/>	11B. Impairment <input type="checkbox"/>							
12. REPRESENTATIVE Sharon Turk									
13. DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED									
14. CLAIMANT DISABLED A. <input type="checkbox"/> Disability Begun	15A. PRIMARY DIAGNOSIS BODY SYS. CODE NO. 12 3180	15B. SECONDARY DIAGNOSIS CODE NO. 4270							
B. <input type="checkbox"/> Disability Ended	Borderline Intellectual Functioning		Cardiac Arrhythmia						
16. CASE OF BUSINESS AS DEFINED IN SEC. 1614(a)(2)(D)(ii)(I)									
17. CLAIMANT NOT DISABLED									
A. <input type="checkbox"/> Not Disab. for Cash Bene. Pmt B. <input type="checkbox"/> Disab. for Cash Bene. Pmt Reg	A. <input checked="" type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (CDB only)								
18. VOCATIONAL BACKGROUND 60-34 J7-1520(f)									
19. PEB/BASIS CODE J7-1520(f)	20. MED LIST NO. DET <input type="checkbox"/>	21. MOP CODE DET <input type="checkbox"/>	22. REVIEWED DET <input type="checkbox"/>	23A. <input type="checkbox"/> Regon A. <input checked="" type="checkbox"/> B. <input type="checkbox"/> C. <input type="checkbox"/> D. <input type="checkbox"/> E. <input type="checkbox"/> F. <input type="checkbox"/>	23B. ED YRS 3+ Spec Ed	23C. VR ACTION Report DHU ALJ Hearings Appeals Council U.S. Board Court F. <input type="checkbox"/>	23D. REINV <input type="checkbox"/>	23E. SC OUT <input checked="" type="checkbox"/> C. <input type="checkbox"/>	23F. Pmt Ref
24. LIST NO.	25. RATIONALE See Attached SSA-4284-U4/CA	26. Check if Vocational Rule Met. Cite Rule							
27. A. <input type="checkbox"/> Period of Disability DOS 0/6 443	B. <input type="checkbox"/> Disability Period J. Lauer	C. <input type="checkbox"/> Establish Beg. _____ AND 12/15/89	D. <input type="checkbox"/> Continues R. Harroun, M.D.	E. <input type="checkbox"/> Term _____ 12/15/89	28. PHYSICIAN OR MEDICAL SPECIALIST SIGNATURE ROBERT HARROUN, M.D. 45				
29. REMARKS Review performed by psychologist/psychiatrist.					30. MULTIPLE IMPAIRMENTS CONSIDERED A. COMBINED MULTIPLE IMPAIRMENTS-ONE B. COMBINED MULTIPLE IMPAIRMENTS-MORE THAN ONE				
31. BASIS CODE Form SSA-831-CF 8-88	32. REV DET CODES	33. SSA-REPRESENTATIVE	34. SSA CODE	35. DATE					
Folder Copy					Electronic Input: <input type="checkbox"/> DECISION <input type="checkbox"/> CASE DOI				

## PSYCHIATRIC REVIEW TECHNIQUE

Name	Larry Hale	SSN	368 66 2961
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Assessment is For:  Current Evaluation  12 Mo. After Onset:

Date Last Insured:  Other: 3/89 10

Reviewer's Signature: *William C. Schirado* Date: 12/3/89  
PSYCHOLOGIST

**PRIVACY ACT NOTICE:** The information requested on this form is authorized by section 223 and section 1633 of the Social Security Act. The information provided will be used in making a decision on this claim. Completion of this form is mandatory in disability claims involving mental impairments. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

### I. MEDICAL SUMMARY

A. Medical Disposition(s):

1.  No Medically Determinable Impairment
2.  Impairment(s) Not Severe
3.  Meets Listing \_\_\_\_\_ (Cite Listing and subsection)
4.  Equals Listing \_\_\_\_\_ (Cite Listing and subsection)
5.  Impairment Severe But Not Expected to Last 12 Months
6.  RFC Assessment Necessary (i.e., a severe impairment is present which does not meet or equal a listed impairment)
7.  Referral to Another Medical Specialty (necessary when there is a coexisting nonmental impairment) (Except for OHA reviewers)
8.  Insufficient Medical Evidence (i.e., a programmatic documentation deficiency is present) (Except for OHA reviewers)

B. Category(ies) Upon Which the Medical Disposition(s) is Based:

1.  12.02 Organic Mental Disorders
2.  12.03 Schizophrenic, Paranoid and other Psychotic Disorders
3.  12.04 Affective Disorders
4.  12.05 Mental Retardation and Autism
5.  12.06 Anxiety Related Disorders
6.  12.07 Somatoform Disorders
7.  12.08 Personality Disorders
8.  12.09 Substance Addiction Disorders

*Duel Run*

- 
- II. REVIEWER'S NOTES (Except OHA reviewers. OHA reviewers should record the subject information in the body and findings of their decision.):** A. Record below the pertinent signs, symptoms, findings, functional limitations, and the effects of treatment contained in the case. B. Remarks (any information the reviewer may wish to communicate which is not covered elsewhere in the form, e.g., duration situations).

**C. 12.04 Affective Disorders**

No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)

Disturbance of mood, accompanied by a full or partial manic or depressive syndrome, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Depressive syndrome characterized by at least four of the following:

- a.  Anhedonia or pervasive loss of interest in almost all activities, or
- b.  Appetite disturbance with change in weight, or
- c.  Sleep disturbance, or
- d.  Psychomotor agitation or retardation, or
- e.  Decreased energy, or
- f.  Feelings of guilt or worthlessness, or
- g.  Difficulty concentrating or thinking, or
- h.  Thoughts of suicide, or
- i.  Hallucinations, delusions or paranoid thinking

2.    Manic syndrome characterized by at least three of the following:

- a.  Hyperactivity, or
- b.  Pressures of speech, or
- c.  Flight of ideas, or
- d.  Inflated self-esteem, or
- e.  Decreased need for sleep, or
- f.  Easy distractability, or
- g.  Involvement in activities that have a high probability of painful consequences which are not recognized, or
- h.  Hallucinations, delusions or paranoid thinking

3.    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)

4.    Other \_\_\_\_\_

**III. DOCUMENTATION OF FACTORS THAT EVIDENCE THE DISORDER (COMMENT ON EACH BROAD CATEGORY OF DISORDER.)**

**A. 12.02 Organic Mental Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Psychological or behavioral abnormalities associated with a dysfunction of the brain . . . as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Disorientation to time and place
2.    Memory impairment
3.    Perceptual or thinking disturbances
4.    Change in personality
5.    Disturbance in mood
6.    Emotional lability and impairment in impulse control
7.    Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., the Luria-Nebraska, Halstead-Reitan, etc.
8.    Other \_\_\_\_\_

**B. 12.03 Schizophrenic, Paranoid and other Psychotic Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Psychotic features and deterioration that are persistent (continuous or intermittent), as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Delusions or hallucinations
2.    Catatonic or other grossly disorganized behavior
3.    Incoherence, loosening of associations, illogical thinking, or poverty of content of speech if associated with one of the following:
  - a.  Blunt affect, or
  - b.  Flat affect, or
  - c.  Inappropriate affect
4.    Emotional withdrawal and/or isolation
5.    Other \_\_\_\_\_

**D. 12.05 Mental Retardation and Autism**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Significantly subaverage general intellectual functioning with deficits in adaptive behavior initially manifested during the developmental period (before age 22), or pervasive developmental disorder characterized by social and significant communicative deficits originating in the developmental period, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Mental incapacity evidenced by dependence upon others for personal needs (e.g., toileting, eating, dressing or bathing) and inability to follow directions, such that the use of standardized measures of intellectual functioning is precluded\*
2.    A valid verbal, performance, or full scale I.Q. of 59 or less\*
3.    A valid verbal, performance, or full scale I.Q. of 60 to 69 inclusive and a physical or other mental impairment imposing additional and significant work-related limitation of function\*
4.    A valid verbal, performance, or full scale I.Q. of 60 to 69 inclusive or in the case of autism, gross deficits of social and communicative skills\*
5.    Other \_\_\_\_\_

\*NOTE: Items 1, 2, 3, and 4 correspond to Listings 12.05A, 12.05B, 12.05C, and 12.05D, respectively.

**E. 12.06 Anxiety Related Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Anxiety as the predominant disturbance or anxiety experienced in the attempt to master symptoms, as evidenced by at least one of the following:

**PRESENT-ABSENT-INSUFFICIENT EVIDENCE**

1.    Generalized persistent anxiety accompanied by three of the following:
  - a.  Motor tension, or
  - b.  Autonomic hyperactivity, or
  - c.  Apprehensive expectation, or
  - d.  Vigilance and scanning
2.    A persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity, or situation
3.    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
4.    Recurrent obsessions or compulsions which are a source of marked distress
5.    Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress
6.    Other \_\_\_\_\_

**F. 12.07 Somatoform Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Physical symptoms for which there are no demonstrable organic findings or known physiological mechanisms, as evidenced by at least one of the following:

## PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1.    A history of multiple physical symptoms 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
2.    Persistent nonorganic disturbance of one of the following:
  - a.  Vision, or
  - b.  Speech, or
  - c.  Hearing, or
  - d.  Use of a limb, or
  - e.  Movement and its control (e.g., coordination disturbances, psychogenic seizures, akinesia, dyskinesia), or
  - f.  Sensation (e.g., diminished or heightened)
3.    Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury
4.    Other \_\_\_\_\_

**G. 12.08 Personality Disorders**

- No evidence of a sign or symptom CLUSTER or SYNDROME which appropriately fits with this diagnostic category. (Some features appearing below may be present in the case but they are presumed to belong in another disorder and are rated in that category.)
- Inflexible and maladaptive personality traits which cause either significant impairment in social or occupational functioning or subjective distress, as evidenced by at least one of the following:

## PRESENT-ABSENT-INSUFFICIENT EVIDENCE

1.    Seclusiveness or autistic thinking
2.    Pathologically inappropriate suspiciousness or hostility
3.    Oddities of thought, perception, speech and behavior
4.    Persistent disturbances of mood or affect
5.    Pathological dependence, passivity, or aggressivity
6.    Intense and unstable interpersonal relationships and impulsive and damaging behavior
7.    Other \_\_\_\_\_

**H. 12.09 Substance Addiction Disorders:** Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

Present — Absent — Insufficient Evidence

If present, evaluate under one or more of the most closely applicable listings:

1.  Listing 12.02—Organic mental disorders\*
2.  Listing 12.04—Affective disorders\*
3.  Listing 12.06—Anxiety disorders\*
4.  Listing 12.08—Personality disorders\*
5.  Listing 11.14—Peripheral neuropathies\*
6.  Listing 5.05—Liver damage\*
7.  Listing 5.04—Gastritis\*
8.  Listing 5.08—Pancreatitis\*
9.  Listing 11.02 or 11.03—Seizures\*
10.  Other \_\_\_\_\_

\*NOTE: Items 1, 2, 3, 4, 5, 6, 7, 8, and 9 correspond to Listings 12.09A, 12.09B, 12.09C, 12.09D, 12.09E, 12.09F, 12.09G, 12.09H, and 12.09I, respectively. If items 1, 2, 3, or 4 are checked, only the numbered items in subsections IIIA, IIIC, IIIE, or IIIG of the form need be checked. The first two blocks under the disorder heading in those subsections need not be checked.

**IV. RATING OF IMPAIRMENT SEVERITY****A. "B" Criteria of the Listings**

Indicate to what degree the following functional limitations (which are found in paragraph B of listings 12.02-12.04 and 12.06-12.08 and paragraph D of 12.05) exist as a result of the individual's mental disorder(s).

NOTE: Items 3 and 4 below are more than measures of frequency. Describe in part II of this form (Reviewer's Notes) the duration and effects of the deficiencies (item 3) or episodes (item 4). Please read carefully the instructions for the completion of this section.

Specify the listing(s) (i.e., 12.02 through 12.09) under which the items below are being rated 12.05.

FUNCTIONAL LIMITATION	DEGREE OF LIMITATION					Insufficient Evidence
	None <input type="checkbox"/>	Slight <input type="checkbox"/>	Moderate <input checked="" type="checkbox"/>	Marked* <input type="checkbox"/>	Extreme <input type="checkbox"/>	
1. Restriction of Activities of Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
2. Difficulties in Maintaining Social Functioning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
3. Deficiencies of Concentration, Persistence or Pace Resulting in Failure to Complete Tasks in a Timely Manner (in work settings or elsewhere)	Never <input type="checkbox"/>	Seldom <input type="checkbox"/>	Often <input checked="" type="checkbox"/>	Frequent* <input type="checkbox"/>	Constant <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>
4. Episodes of Deterioration or Decompensation in Work or Work-Like Settings Which Cause the Individual to Withdraw from that Situation or to Experience Exacerbation of Signs and Symptoms (which may Include Deterioration of Adaptive Behaviors)	Never <input checked="" type="checkbox"/>		Once or Twice <input type="checkbox"/>	Repeated* (three or more) <input type="checkbox"/>	Continual <input type="checkbox"/>	Insufficient Evidence <input type="checkbox"/>

**B. Summary of Functional Limitation Rating for "B" Criteria**

Indicate the number of the above functional limitations manifested at the degree of limitation that satisfies the Listings.  (The number in the box must be at least 2 to satisfy the requirements of paragraph B in Listings 12.02, 12.03, 12.04, and 12.06 and paragraph D in 12.05; and at least 3 to satisfy the requirements in paragraph B in Listings 12.07 and 12.08.)

\*Degree of limitation that satisfies the Listings. Extreme, Constant and Continual also satisfy that requirement.

C. "C" Criteria of the Listings

1. If 12.03 Disorder (Schizophrenic, etc.) and in Full or Partial Remission

NOTE: Item b. below is more than a measure of frequency. Describe in part II of this form (Reviewer's Notes) the duration and effects of the episodes. Please read carefully the instructions for the completion of this section.

Present    Absent    Insufficient  
Evidence

- a.             Medically documented history of one or more episodes of acute symptoms, signs and functional limitations which at the time met the requirements in A and B of 12.03, although these symptoms or signs are currently attenuated by medication or psychosocial support.
- b.             Repeated episodes of deterioration or decompensation in situations which cause the individual to withdraw from the situation or to experience exacerbation of signs or symptoms (which may include deterioration of adaptive behaviors).
- c.             Documented current history of two or more years of inability to function outside of a highly supportive living situation.

(For the requirements in paragraph C of 12.03 to be satisfied, either a. and b. or a. and c. must be checked as present.)

2. If 12.06 Disorder (Anxiety Related)

Present    Absent    Insufficient  
Evidence

- Symptoms resulting in complete inability to function independently outside the area of one's home.

(If present is checked, the requirements in paragraph C of 12.06 are satisfied.)

## MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

NAME <i>Larry Hale</i>	SOCIAL SECURITY NUMBER <i>348 66 2761</i>
CATEGORIES (From 1B of the PRTF)	ASSESSMENT IS FOR:
	<input checked="" type="checkbox"/> Current Evaluation <input type="checkbox"/> 12 Months After Onset:
	<input type="checkbox"/> Date Last Insured: _____ (Date) _____
	<input checked="" type="checkbox"/> Other: <i>5/89</i> <input type="checkbox"/> to _____ (Date) _____ (Date) _____

**I. SUMMARY CONCLUSIONS**

This section is for recording summary conclusions derived from the evidence in file. Each mental activity is to be evaluated within the context of the individual's capacity to sustain that activity over a normal workday and workweek, on an ongoing basis. Detailed explanation of the degree of limitation for each category (A through D), as well as any other assessment information you deem appropriate, is to be recorded in Section III (Functional Capacity Assessment).

If rating category 5 is checked for any of the following items, you MUST specify in Section II the evidence that is needed to make the assessment. If you conclude that the record is so inadequately documented that no accurate functional capacity assessment can be made, indicate in Section II what development is necessary, but DO NOT COMPLETE SECTION III.

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Rateable on Available Evidence
<b>A. UNDERSTANDING AND MEMORY</b>					
1. The ability to remember locations and work-like procedures.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The ability to understand and remember very short and simple instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. The ability to understand and remember detailed instructions.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
4. The ability to carry out very short and simple instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. The ability to carry out detailed instructions.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The ability to maintain attention and concentration for extended periods.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The ability to sustain an ordinary routine without special supervision.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The ability to work in coordination with or proximity to others without being distracted by them.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. The ability to make simple work-related decisions.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not Significantly Limited	Moderately Limited	Markedly Limited	No Evidence of Limitation in this Category	Not Ratable on Available Evidence
<b>Continued—SUSTAINED CONCENTRATION AND PERSISTENCE</b>					
11. The ability to complete a normal work-day and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>C. SOCIAL INTERACTION</b>					
12. The ability to interact appropriately with the general public.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
13. The ability to ask simple questions or request assistance.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
15. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>D. ADAPTATION</b>					
17. The ability to respond appropriately to changes in the work setting.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
18. The ability to be aware of normal hazards and take appropriate precautions.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
19. The ability to travel in unfamiliar places or use public transportation.	1. <input checked="" type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
20. The ability to set realistic goals or make plans independently of others.	1. <input type="checkbox"/>	2. <input checked="" type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>	5. <input type="checkbox"/>
<b>B. REMARKS:</b> If you checked box 5 for any of the preceding items or if any other documentation deficiencies were identified, you <b>MUST</b> specify what additional documentation is needed. Cite the item number(s), as well as any other specific deficiency, and indicate the development to be undertaken.					

Continued on Page 3

Continued on Page 4

### III. FUNCTIONAL CAPACITY ASSESSMENT

Record in this section the elaborations on the preceding capacities. Complete this section ONLY after the SUMMARY CONCLUSIONS section has been completed. Explain your summary conclusions in narrative form. Include any information which clarifies limitation or function. Be especially careful to explain conclusions that differ from those of treating medical sources or from the individual's allegations.

3190 DD 73/88/78

Drives, does chores independently.

In social contact but no beh. extremes

Independent & safe tasks.

Poss., sustain., quality, first tol. at  
for safe tasks.

Continued on Page 4

MEDICAL CONSULTANT'S SIGNATURE

Form SSA-4734-F4-SUP (Rev. 6-65)

DR. WILLIAM C. SCHIRADO  
PSYCHOLOGIST

DATE

12/3/89

SA Consultant 1/31/80 CMM

District: N-193 VRSSSN: 368-66-2961

## TELEPHONE REPORT OF CONTACT

Name of Wage Earner:

Larry R. Hale

Person Contacted:

Sandra Hale - wife

Contact Made:

 Phone  Other

Date of Contact:

1/26/80

SUBJECT:

According to Mrs. Hale, Larry doesn't understand what people are saying to him. He will talk with others, but can't tell what was said to him. Mrs. Hale said it took her awhile to realize this because he appears to understand until questioned about it. She accompanies him to all appointments because he has difficulty explaining himself. For example he has difficulty describing his chest pain.

Mrs. Hale also does all of the business, such as taking care of bills. Larry has difficulty handling money and knowing if he is getting the correct change. She gave him \$3.00 bill to get a quart of milk. He returned with \$2.00 in change.

Signature of DDS Interviewer

C. M. Nitke

Page 1 of 4

Signature of Person Contacted

DATE

SA Consultant

Date \_\_\_\_\_ Initial \_\_\_\_\_

 VRS

Date \_\_\_\_\_ Initial \_\_\_\_\_

## TELEPHONE REPORT OF CONTACT

District: N-183

SSN:

368-66-2761

Name of Wage Earner:

Larry R Hale

Person Contacted:

Sandra Hale - wife

Contact Made:

 Phone     Other

Date of Contact:

SUBJECT:

1/26/90

Larry can only read easy words such as "the & love." He also can't spell or write without asking her how to spell words.

Larry does drive, but not without her. He needs help with directions. When they went to the dentist earlier he knew the area but she needed to help him locate the building. He also thinks when the gas gage is on 1/2 tank, it is empty.

During the day he wants to sleep all the time. She has to urge him to do things. He usually lays and watches T.V. Mrs Hale doesn't think he understands what he sees because he asks her what's going on and she has to read captions. He does try to help with housework at times, such as dishes and vacuuming, but she usually has to do

Signature of DDS Interviewer

C M Nutys

Signature of Person Contacted

Page 3 of 9

DATE

District: N-183

SSN:

368-66-2761

Name of Wage Earner:

Larry R Hale

TELEPHONE REPORT OF CONTACT

District: N-1R3

SSN: 368-66-2761

Name of Wage Earner:

Larry & Hale

TELEPHONE REPORT OF CONTACT

Person Contacted:

Sandra Hale

Contact Made:

Phone  Other

Date of Contact:

1/26/70

SUBJECT:

it over. If he goes to the laundry room  
of their apartment building, he doesn't  
want to stay, and wanders off.

They were married Nov 9, but she knew  
him 5/87.

I also had a Holter Monitor as outpatient  
at Mercy Hosp (Benton Harbor) on 1/23/70. This  
was ordered by Dr. Rambo.

Signature of DDS Interviewer

C. McTigue

Page 9 of 9

Signature of Person Contacted

Sandra Hale

DATE

1-2-90

NAME: Larry R. Nale

SSN: 3607-66-2961  
DISTRICT: M/165

DAILY ACTIVITIES

Describe your daily activities in the following areas:

A. PERSONAL CARE

1. What time do you usually get up and go to bed? around 10:00
2. Do you have any trouble sleeping at night? If so, explain:  
wakes up during the night
3. Do you usually take naps during the day? If so, how long and why?  
I never get tired
4. Have your sleeping habits changed since your illness began? If so, explain:  
get restless during the night
5. Do you need any special help to take care of your personal needs and grooming? If so, explain what kinds of help you require (washing, bathing, dressing, etc.), why, and how often:  
No not at this time.
6. Have there been any changes in your sleep habits or ability to care for your personal needs since your illness began? If so, EXPLAIN:  
No

B. HOUSEHOLD CARE

1. Do you fix your own meals? yes If yes, which meals do you usually prepare Cereals Breakfast Hot dogs my Mother's Boyfriend Lunch Dinner
2. What kind of food do you usually fix? Explain:  
Hot dogs, Hamburger  
Hot Cereal
3. Does anyone help you fix meals? If yes, explain why and how often:  
Sometimes, I really don't know how to cook
4. Do you fix meals for more than just yourself? If yes, explain:  
No
5. Do you eat more, less, or the same amount since your illness began?  
Has there been a change in your weight since your illness began? EXPLAIN:  
less  
yes, weight gain and then loss

C. INTERESTS AND HOBBIES

1. Do you read? If yes, what do you usually read (books, newspapers, magazines)?

No

2. What is your favorite reading subject(s)?

 

3. How long do you usually read at a time?

 

4. Do you watch TV or Listen to the radio? both If yes:

- a. What kinds of programs do you usually watch or listen to?

Movies

- b. How long do you watch TV or listen to the radio every day?

I watch I get tired and need to rest

5. Do you spend time on any hobbies, interests, or other activities?

No If yes:

- a. What kinds of hobbies, interests, or other activities (fishing, bowling, sewing, swimming, handwork, sports, movies, hunting)?

- b. How often do you do these activities (daily, weekly, twice a week, etc.)?

- c. How much time do you usually spend on these activities?

- d. Do you need help with your hobbies and activities?

If yes, explain why and how often:

6. Has interest in your hobbies and activities changed since your illness began? If so, EXPLAIN:

 

D. SOCIAL CONTACTS

1. Do you visit with friends or family? yes If yes, show:

- a. How often do you visit them or they visit you? whenever

- b. Whom do you visit with?

relatives and friends

18A. Check each item to indicate if any difficulty was observed:

Reading	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Using Hands	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Writing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Answering	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Walking	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sitting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Specify): _____		
Understanding	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

18B. If any of the above items were checked "yes," describe the exact difficulty involved:

18C. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above, etc.)

Clean, Polite & Co-operative. Came into DO. with Mother, & a friend of his mother. He could not remember any dates of my & divorce or dates worked and Mother helped him answer.

19. Medical Development — Initiated by District or Branch Office

SOURCE	DATE REQUESTED	DATE(S) OF FOLLOW-UP	CAPABILITY DEVELOPMENT REQUESTED

20. DO or BO curtailed completion of Parts III - V per DI 00403.105  
(DI 00401.065)  YES  NO

21. Is capability development by the DDS necessary?  
If "yes", show "DDS capability development needed" in item 11 of the SSA-831-US  YES  NO

22. Is development of work activity necessary?  
If "yes", is an SSA-820-F4 or SSA-821-F4  YES  NO  
 Pending  In File

23. SSA-3368-FB taken by:  
 Personal Interview  Telephone  Mail  Yes  No  
 Pending  In File

SIGNATURE OF DO OR BO INTERVIEWER OR REVIEWER  
*J.L. Turk*  Title *CR*  Date *8/25/89*

## DISABILITY REPORT

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

**PRIVACY ACT/PAPERWORK REDUCTION ACT NOTICE:** The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1633(j) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim and could result in the loss of benefits. Although the information you furnish on this form is almost never used for any purpose other than making a determination on your disability claim, such information may be disclosed by the Social Security Administration as follows: (1) To enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Veterans Administration); and (3) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security). These and other reasons why information about you may be used or given out are explained in the *Federal Register*. If you would like more information about this, any Social Security office can assist you.

A. NAME OF CLAIMANT <i>LARRY ROBERT HALE</i>	B. SOCIAL SECURITY NUMBER <i>368/66/2961</i>	C. TELEPHONE NUMBER where you can be reached (include area code) <i>(616) 927-1183</i>
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D. WHAT IS YOUR DISABLING CONDITION? (Briefly explain the injury or illness that stops you from working.)

*HEART PROBLEM  
SLOW LEARNER  
& LEARNING DISABLED (SPECIAL EDUCATION)  
ALL THROUGH SCHOOL SINCE 3<sup>RD</sup> GRADE*

## PART I — INFORMATION ABOUT YOUR CONDITION

1. When did your condition first bother you?	MONTH ?	DAY ?	YEAR 88
2A. Did you work after the date shown in item 1? (If "no", go on to items 3A and 3B.)	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
2B. If you did work since the date in item 1, did your condition cause you to change —			
Your job or job duties?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
Your hours of work?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
Your attendance?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
Anything else about your work?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		

(If you answered "no" to all of these, go to items 3A and 3B.)

2C. If you answered "yes" to any item in 2B, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary.

3A. When did your condition finally make you stop working?	MONTH 5	DAY 15	YEAR 89
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3B. Explain how your condition now keeps you from working.

*When doing strenuous work my heart starts beating to fast and pains comes into my chest. I also have problems breathing.*

## DISABILITY DETERMINATION AND TRANSMITTAL

1. DESTINATION <input checked="" type="checkbox"/> DSBW <input type="checkbox"/> DOO <input type="checkbox"/> DRB <input type="checkbox"/> DOB <input type="checkbox"/> INTPSC	2. DOS CODE 234	3. FILING DATE 8/25/89	4. SSN 368-66-2941	5. BIC # (COB or DWB CLAIM) 
6. NAME AND ADDRESS OF CLAIMANT (Include ZIP Code)		6. WEE'S NAME (If COB or DWB CLAIM)		
<i>Harry Hale 7292 Red Arrow Hwy Stevensville, MI 49127</i>				
7. DATE OF BIRTH 2/10/58		8. PRODUCTION <input checked="" type="checkbox"/> PD <input type="checkbox"/> PT		
10. DISTRICT-BRANCH OFFICE ADDRESS (Include ZIP Code) 225 Colfax Ave Benton Harbor, MI 49127-365		11. REMARKS		
12. DO-BO REPRESENTATIVE MRN		13. DATE 08/01/93		
14A. PRIMARY DIAGNOSIS BODY SYM. CODE NO. 14B. SECONDARY DIAGNOSIS CODE NO.				
14. CLAIMANT DISABLED <input checked="" type="checkbox"/> Disability Began 5/13/89		14A. Primary Diagnosis BODY SYM. CODE NO. 14B. Secondary Diagnosis CODE NO.		
B. <input type="checkbox"/> Disability Ceased		<i>Mental Retardation Personality Disorder</i>		
15. DATES 08/01/93		16. CLAIMANT NOT DISABLED		
18. CASE OF BLINDNESS AS DEFINED IN SEC. 1814(a)(2)(D)(ii)		19. CLAIMANT NOT DISABLED		
A. <input type="checkbox"/> Not Disab. for Cash Bene. <input type="checkbox"/> Prop.		A. <input type="checkbox"/> Through Date of Current Determination B. <input type="checkbox"/> Through _____ C. <input type="checkbox"/> Before Age 22 (COB only)		
B. <input type="checkbox"/> Disab. for Cash Bene. <input type="checkbox"/> Prop. Beg.		DCC YRS. 10 YRS. 21. VR ACTION A. <input type="checkbox"/> BGIN B. <input checked="" type="checkbox"/> RECDL C. <input type="checkbox"/> PPA RET		
20. VOCATIONAL BACKGROUND 60/34		20A. RECDL REC'D. REC'D. DHU ALJ Hearing Appeals Council U.S. Court of Comp. Ct.		
22. REG-BASIS CODE C1-1520(f)		23. MED-LIST NO. 24. MOB CODE 25. RENCODE DET <input checked="" type="checkbox"/>		
26. LIST NO. A. B.		C. D. E. F.		
27. RATIONALE <input type="checkbox"/> See Attached SSA-4268-U4/C4		28. C. <input type="checkbox"/> Estab Beg. 8/13/89 AND D. <input type="checkbox"/> Continues E. <input type="checkbox"/> Term _____		
29. LTR/PAR NO.		30. DISABILITY EXAMINER-DOS 31. DATE 32. PHYSICIAN OR MEDICAL SPEC. SIGNATURE 33. DATE		
		<i>Amber CM Inter 3/8/90</i> <i>Kenneth J. Hobbs</i> 3/9/90		
34A. PHYSICIAN OR MEDICAL SPEC. NAME, Print or Type		34B. SPEC. CODE 37		
35. REMARKS <i>Recon Reversal Claimant capable as per Dr Bacchus report dated 2/19/90</i>				
35. BASIS CODE -1		36. SSA REPRESENTATIVE CODES <i>Dale</i> <i>Jean Anne</i> <i>D. Dry</i>		
37. REV DET. CODES		38. SSA CODE 38. DATE 12 3/15/90		
Form SSA-831-U3 (3/89) Prior editions may be used until supply is exhausted				
Electronic File: <input type="checkbox"/> DECISION <input type="checkbox"/> CASE CONTROL Folder Copy				

<input type="checkbox"/> SA Contacted	date	initial	District: N-193
<input type="checkbox"/> VRS	date	initial	SSN: 368-66-2961
TELEPHONE REPORT OF CONTACT			Name of Wage Earner: Larry R. Hale
Person Contacted: Sandra Hale - wife			
Contact Made: <input checked="" type="checkbox"/> Phone <input type="checkbox"/> Other	Date of Contact: 1/26/90		
SUBJECT:			
<p>Larry also has problems with memory. He can't remember what day of the week it is and is always asking her. She also has to remind him when to change his clothes and to bathe. She lays his clothes out for him because he doesn't know how to dress for the weather.</p> <p>He has difficulty getting along with others and has mood changes, like a split personality. He just flies off the handle for known reason. This is verbally, not physically. He has seen him do this with (her) mother and friends, as well as her self. He has had one friend, the best man at their wedding, visit since July. He came one time and never came back. Larry is a loner and doesn't do any visiting.</p>			
Signature of DDS Interviewer C. Mc Intyre		Page 2 of 4	
Signature of Person Contacted		DATE	

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PART III — INFORMATION ABOUT WORK

9. Have you worked since you filed your claim? .....  Yes  No

If "Yes," you will be asked to give details on a separate form.

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PART IV — INFORMATION ABOUT YOUR ACTIVITIES

10. How does your illness or injury affect your ability to care for your personal needs?

Every day living - people have to make decisions and help him and show him how to do things and read things to him. He can't lay flat or take trash out because of getting out of breath.

11. What changes have occurred in your daily activities since you filed your claim?  
(If none, show, "None")

It's the same as before

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PART V — REMARKS AND AUTHORIZATIONS

12.(a) READ CAREFULLY; I authorize the Social Security Administration to release information from my records, as necessary to process my claim, as follows:

Copies of my medical records may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.

Information from my records may also be furnished, if necessary, to any company providing clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The State Vocational Rehabilitation Agency may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand and concur with the statement and authorizations given above, except as follows (if there are no exceptions, write "None" in the space below. If you do not concur with any part of the above statement, state your objections clearly):

12.(b)	Telephone number where you can be reached:  <u>(614) 465-0379</u>	Best time to reach you:  <u>ANY TIME</u>
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## PART VI — FOR SSA USE ONLY — DO NOT WRITE BELOW THIS LINE

Name of Wage Earner <b>LARRY HALE</b>	Social Security Number <b>368-66-2961</b>
Name of Claimant <b>SAME</b>	Social Security Number <b>SAME</b>

13. Check each item to indicate whether or not any difficulty was observed:  
(Explain all items checked "Yes," in Item 14 below)

Reading:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Using Hands:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Writing:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Breathing:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Answering:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Seeing:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Hearing:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Walking:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Speaking:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Sitting:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Understanding:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Assistive Devices:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Other (Specify):					

14. If any of the above items were checked "Yes," describe the observed difficulty.

Mr Hale looked down most of the time. He answered very few questions & let his wife answer most of them.

15. Describe fully: General appearance, behavior, any unusual observed difficulties not noted elsewhere, any unusual circumstances surrounding the interview.

Average height & weight. Seemed unable to concentrate on questions being asked.

		District: <i>N-193</i>
		SSN: <i>368-66-2961</i>
TELEPHONE REPORT OF CONTACT		Name of Wage Earner: <i>Larry R Hale</i>
Person Contacted: <i>Sandra Hale - wife</i>		
Contact Made:	<input checked="" type="checkbox"/> Phone <input type="checkbox"/> Other	Date of Contact: <i>3/6/90</i>
SUBJECT:		
<p>Mrs. Hale has known Larry for about a year. Since she has known him he has had problems with understanding what others are saying and has always preferred to let her or his mother explain things to his doctors and answer questions for him.</p> <p>Mrs. Hale doesn't know how he was able to hold a job.</p>		
Signature of DDS Interviewer <i>C. M. Whyte</i>		Page    of
Signature of Person Contacted		DATE