XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''; SSR 98–1p, Determining Medical Equivalence in Title XVI Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; 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.

[FR Doc. E9–3379 Filed 2–13–09; 8:45 am]

BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062; Social Security Ruling, SSR 09–5p]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Interacting and Relating With Others''

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–5p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Interacting and relating with others.'' It also explains our policy about that domain.

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

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

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. 20 CFR 402.35(b)(1).

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—The Functional Equivalence Domain of ''Interacting and Relating With Others''

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Interacting and relating with others.'' It also explains our policy about that domain.

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

As we explain in greater detail in SSR 09–1p, we always evaluate the ''whole child'' when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.[6] We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.[7]

We next evaluate the effects of a child's impairment(s) by rating the degree to which the impairment(s) limits functioning in six ''domains.'' *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).[8]

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

---

[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 1614(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.

[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* SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The ''Whole Child'' Approach.

[7] However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child's limitations in functioning, as described in the following paragraphs, we must consider any variations in the child's level of functioning to determine the impact of the chronic illness on the child's ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child's limitations, *see* SSR 09–1p. For a comprehensive discussion of how we document a child's functioning, including evidentiary sources, *see* SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations.

[8] 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.''

functioning or an ''extreme'' limitation in one domain.[9] 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of ''Interacting and relating with others,'' we consider a child's ability to initiate and respond to exchanges with other people, and to form and sustain relationships with family members, friends, and others. This domain includes all aspects of social interaction with individuals and groups at home, at school, and in the community. Important aspects of both interacting and relating are the child's response to persons in authority, compliance with rules, and regard for the possessions of others. In addition, because communication is essential to both interacting and relating, we consider in this domain the speech and language skills children need to speak intelligibly and to understand and use the language of their community.

The ability to interact and relate with others begins at birth. Children begin to use this ability in early infancy when they bond with caregivers, and use it in increasingly complicated ways as they develop and grow older.

This ability is involved in a broad range of childhood activities, such as playing, learning, and working cooperatively with others, either one-on-one or in groups. To interact and relate effectively in any activity, a child must be able to recognize, understand, and respond appropriately to emotional and behavioral cues from other people. A child whose impairment(s) limits the ability to interact and relate with others may have various kinds of difficulties. For example, the child may not understand:

- How to approach other children,
- How to initiate and sustain social exchanges, and
- How to develop meaningful relationships with others.

Children with impairment-related limitations in this domain may not be disruptive; therefore, their limitations may go unnoticed. Such children may be described as socially withdrawn or isolated, without friends, or preferring to be left alone. These children may simply not understand how to accomplish social acceptance and integration with other individuals or groups.[10] However, because children achieve much of their understanding about themselves and the world from their interactions, the impairment-related limitations of children who withdraw from social interaction may be as significant as those of children whose impairments cause them to be disruptive.

As with limitations in any domain, we do not consider a limitation in the domain of ''Interacting and relating with others'' unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty interacting and relating with others from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

Interacting With Others

To interact effectively with others, children must understand how to approach another person or a group of people, and must know how to respond in an age-appropriate manner to others who approach them. They must be able to use not only words, but facial expressions, gestures, and actions. The child must also be able to use these forms of communication with different people and in different contexts throughout the day. In addition, when interacting with a parent, teacher, or other adult, the child needs to convey respect for the adult. When interacting with peers, the child needs to convey willingness to play fairly and follow the rules, consistent with expectations for the child's age. A child's interactions may be limited to a single exchange, as when buying candy at a neighborhood store, or more frequent ones, as when answering a younger sibling's questions. They may occur one-on-one, as when talking on the telephone, or in groups, as when playing with friends or participating in an organized sport.

Both physical and mental impairments can affect a child's ability to interact with others. For example, a child with a hearing impairment or abnormality of the speech mechanism (such as a repaired cleft palate) may have speech that is difficult to understand. Such a child may have difficulty describing an event to strangers. A child with attention-deficit/hyperactivity disorder may antagonize others by impulsively cutting into a line.

Relating With Others

To relate effectively with others, a child must be able to form relationships with family members, friends, and others, and to sustain those relationships over time in an age-appropriate manner. Creating relationships with others builds upon effective interaction, and involves awareness and consideration of others' feelings, helpful and cooperative behaviors, and continuing interest in the relationships.

Both physical and mental impairments can affect a child's ability to relate with others. For example, a child with a physical abnormality, such as a disfiguring burn, a missing limb, or an abnormal gait, or who uses adaptive equipment because of the impairment(s), may have difficulty making friends. A child with an anxiety disorder may be extremely uncomfortable around other children and may have difficulty spending enough time with others to maintain friendships. An autism spectrum disorder may limit a child's emotional and social responses to others.

The role of communication in interacting and relating with others

The ability to interact and relate with others requires the ability to communicate in an age-appropriate manner.[11] To communicate with others, a child needs both *speech* and *language. Speech* is the production of sounds for the purpose of oral communication.[12] *Language* provides the message of communication. It involves understanding what is heard and read (*receptive language*) and expressing what one wants to say to others, either orally or in writing (*expressive language*).[13] Within age-appropriate expectations, a child must speak clearly enough to be understood, understand the message that another person is communicating, and formulate sentences well enough to convey a

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

[10] The mere fact that a child prefers to be alone or does not have many friends, however, does not necessarily mean that there is a limitation that should be evaluated in this domain. There must be a limitation that results from a medically determinable impairment(s).

[11] The ability to communicate is first manifested at birth. Even before speaking their first words, infants communicate through gestures and vocalizations to express feelings and needs.

[12] In addition to *articulation* (which relates to clarity), speech also concerns *fluency* (which relates to the flow of speech) and *voice* (which relates to vocal quality, pitch, and intensity). For a comprehensive discussion of speech issues in childhood disability cases, including guidelines for evaluating the severity of speech impairments, *see* SSR 98–1p, Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech.

[13] When we evaluate the communication ability of children who speak a language other than English, we consider their use of their primary language (first language learned) and English. Otherwise, we might erroneously find limitations in ''Interacting and relating with others'' (or any other domain) when children are, for example, simply learning a second language or demonstrating dialectal differences.

message. An impairment(s) may affect speech, language, or both speech and language.

Communication involves using and understanding both verbal and nonverbal skills in conversation. This is the social aspect of communication, also referred to as *pragmatics.* It involves *verbal* skills related to vocabulary choice and sentence formulation, and *non-verbal* skills, such as maintaining eye contact and using gestures, facial expressions, and physical postures.[14] It also involves other ''rules'' or conversational skills, such as turn-taking, introducing and maintaining a topic, asking for clarification or giving feedback when appropriate, and using effective techniques for opening, maintaining, and closing a conversation.

When *speaking* in a conversation, a child must decide what to say and how to say it, using appropriate vocabulary and following the rules of grammar to communicate the intended message. In addition, the child must consider factors that can influence the expression of the message, including the identity of the listener (for example, parent, teacher, sibling, or friend) and the child's relationship to the listener (for example, how the child states a request to an authority figure or to a peer). The child must also pay attention to verbal and nonverbal indications of whether the listener understands the message and, if not, must be able to rephrase the message so as to be understood.

When *listening* in a conversation, a child must follow what is being communicated well enough to understand the message and, if a response is appropriate, to respond in a meaningful way. A child who has difficulty understanding either the verbal or the nonverbal message may not be able to participate appropriately in a conversation. For example, classmates may become impatient or irritated when a child is unable to understand a joke (verbal) or to interpret facial expressions (nonverbal).

The Difference Between the Domains of ''Interacting and Relating With Others'' and ''Caring for Yourself''

The domains of ''Interacting and relating with others'' and ''Caring for yourself'' are related, but different from each other. The domain of ''Interacting and relating with others'' involves a child's feelings and behavior in relation to *other people* (as when the child is playing with other children, helping a grandparent, or listening carefully to a teacher). The domain of ''Caring for yourself'' involves a child's feelings and behavior in relation to *self* (as when controlling stress in an age-appropriate manner).

A decision about which domain is appropriate for the evaluation of a specific limitation depends on the impact of the particular behavior. For example:

- If a girl with hyperactivity interrupts conversations inappropriately, we evaluate this problem in social functioning in the domain of ''Interacting and relating with others.'' However, if she impulsively runs into the street, endangering herself, we evaluate this problem in self-care in the domain of ''Caring for yourself.''
- If a boy with a language disorder avoids other children during playtime, we evaluate this problem in social functioning in the domain of ''Interacting and relating with others.'' But the child may also use language for ''self-talk'' to calm himself down in a stressful situation, so the language disorder may cause a limitation in self-regulation, which we evaluate in the domain of ''Caring for yourself.''

Some impairments may cause limitations in *both* domains. For example, a boy with Oppositional Defiant Disorder who refuses to obey a parent's instruction not to run on a slippery surface, disrespects the parent's authority and endangers himself by running instead of walking. In this case, the child's mental disorder is causing limitations in the domains of ''Interacting and relating with others'' *and* ''Caring for yourself.'' Similarly, a teenage girl with depression who avoids friends and wants to be left alone may also develop poor eating habits as a way of coping with social isolation. We evaluate the limitations resulting from her depression in both the domains of ''Interacting and relating with others'' *and* ''Caring for yourself.'' 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.[15]

Effects in Other Domains

Children with limitations in the ability to interact and relate with others may also have limitations in other domains. For example, learning and thinking also require the ability to communicate, so an impairment(s) affecting communication may cause a limitation that we evaluate in the domain of ''Acquiring and using information'' in addition to the domain of ''Interacting and relating with others.'' Therefore, as in any case, we evaluate the effects of the child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains.

Examples of Typical Functioning in the Domain of ''Interacting and Relating With Others''

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating impairment-related limitations in the domain of ''Interacting and relating with others,'' we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to the ability to interact and relate with others.

1. Newborns and Young Infants (Birth to Attainment of Age 1)

- Begins to form intimate relationships (for example, by gradually responding visually and vocally to a caregiver, and by molding body to caregiver's when held).
- Initiates early interactive games (for example, playing peek-a-boo or pat-a-cake).
- Responds to a variety of emotions (for example, returning a caregiver's smile or crying when others are showing distress).
- Begins to develop speech (beginning with vowels and consonants, first alone and then combined in babbling sounds).

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Begins to separate from caregivers, although is still dependent on them.
- Expresses emotions and responds to the feelings of others.
- Initiates and maintains interactions with adults.
- Begins to understand concept of ''mine'' and ''his'' or ''hers.''
- Shows interest in, plays alongside, and eventually interacts with other children.

---

[14] A child's cultural background may also influence pragmatic behaviors. For example, teachers in many Northern American cultures expect children to maintain eye contact during conversations. Children from Asian backgrounds, however, are often trained to show respect for authority figures by avoiding eye contact.

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

• Communicates wishes or needs, first with gestures and later with words that can be understood most of the time by people who know the child best.

3. Preschool Children (Age 3 to Attainment of Age 6)

• Socializes with children and adults.
• Begins to prefer and develops friendships with playmates the same age.
• Relates to caregivers with increasing independence.
• Uses words instead of actions to express self.
• Is better able to share, show affection, and offer help.
• Understands and obeys simple rules most of the time, and sometimes asks permission.
• Chooses own friends and plays cooperatively without continual adult supervision.
• Initiates and participates in conversations with familiar and unfamiliar listeners, using increasingly complex vocabulary and grammar.
• Speaks clearly enough to be understood by familiar and unfamiliar listeners most of the time.

4. School-Age Children (Age 6 to Attainment of Age 12)

• Develops more lasting friendships with same-age children.
• Increasingly understands how to work in groups to create projects and solve problems.
• Increasingly understands another's point of view and tolerates differences (for example, playing with children from diverse backgrounds).
• Attaches to adults other than parents (for example, teachers or club leaders), and may want to please them to gain attention.
• Shares ideas, tells stories, and speaks in a manner that can be readily understood by familiar and unfamiliar listeners.

5. Adolescents (Age 12 to Attainment of Age 18)

• Initiates and develops friendships with children of the same age.
• Relates appropriately to children of all ages and adults, both individually and in groups.
• Increasingly able to resolve conflicts between self and family members, peers, and others outside of family.
• Recognizes that there are different social rules for dealing with other children than with adults (for example, behaving casually with friends, but more formally with people in authority).
• Describes feelings, seeks information, relates events, and tells stories in all kinds of environments (for example, at home or in school) and with all kinds of people (for example, parents, siblings, friends, or classmates).
• Develops increasing desire for privacy.
• Focuses less attention on parents and more on relationships with peers.

Examples of Limitations in the Domain of ''Interacting and Relating With Others''

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of ''Interacting and relating with others,'' we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a ''marked'' or an ''extreme'' limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a toddler may be appropriately fearful of meeting new people, but a teenager would be expected to interact with strangers more readily.[16]

• Does not reach out to be picked up, touched, and held by a caregiver.
• Has no close friends, or has friends who are older or younger.
• Avoids or withdraws from people he or she knows.
• Is overly anxious or fearful of meeting new people or trying new experiences.
• Has difficulty cooperating with others.
• Has difficulty playing games or sports with rules.
• Has difficulty communicating with others (for example, does not speak intelligibly or use appropriate nonverbal cues when carrying on a conversation).

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 09–6p, 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''; 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; 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] *See* 20 CFR 416.924b.

[FR Doc. E9–3382 Filed 2–13–09; 8:45 am]
BILLING CODE 4191–02–P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062]

Social Security Ruling, SSR 09–6p.; Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving About and Manipulating Objects''

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–6p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Moving about and manipulating objects.'' It also explains our policy about that domain.

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

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

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