• Begins to expand capacity for self-regulation to include rhythmic behaviors (for example, rocking).
• Tries to do things for self, perhaps when still too young (for example, insisting on putting food in mouth, refusing caregiver's help).

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

• Is increasingly able to console self (for example, carrying a favorite blanket).
• Cooperates with caregiver in dressing, bathing, and brushing teeth, but also shows what he can do (for example, pointing to the bathroom, pulling off coat).
• Insists on trying to feed self with spoon.
• Experiments with independence by a degree of contrariness (for example, ''No! No!'') and declaring own identity (for example, by hoarding toys).

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

• Tries to do things that he is not fully able to do (for example, climbing on chair to reach something up high).
• Agrees easily and early in this age range to do what caregiver wants, but gradually wants to do many things her own way or not at all.
• Develops more confidence in abilities (for example, wants to use toilet, feed self independently).
• Begins to understand how to control behaviors that are potentially dangerous (for example, crossing street without an adult).

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

• Recognizes circumstances that lead to feeling good and bad about himself.
• Begins to develop understanding of what is right and wrong, and what is acceptable and unacceptable behavior.
• Demonstrates consistent control over behavior and avoids behaviors that are unsafe.
• Begins to imitate more of the behavior of adults she knows.
• Performs most daily activities independently (for example, dressing, bathing), but may need to be reminded.

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

• Discovers appropriate ways to express good and bad feelings (for example, keeps a diary, exercises).
• Feels more independent from others and becomes increasingly independent in all daily activities.
• Sometimes feels confused about how she feels about herself.
• Notices significant changes in his body's development, which can result in some anxiety or worry about self and body (may sometimes cause anger and frustration).
• Begins to think about future plans (for example, work).
• Maintains personal hygiene adequately (for example, bathing, brushing teeth, wearing clean clothing appropriate for weather and context).
• Takes medications as prescribed.

Examples of Limitations in the Domain of ''Caring for Yourself''

To further assist adjudicators in evaluating impairment-related limitations in the domain of ''Caring for yourself,'' 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, school-age children would be expected to bathe themselves, but toddlers would not; young children may place non-nutritive or inedible objects in their mouth, but older children typically would not.[13]

• Consoles self with activities that show developmental regression (for example, an older child who sucks his thumb).
• Has restrictive or stereotyped mannerisms (for example, head banging, body rocking).
• Does not spontaneously pursue enjoyable activities or interests (for example, listening to music, reading a book).
• Engages in self-injurious behavior (for example, refusal to take medication, self-mutilation, suicidal gestures) or ignores safety rules.
• Does not feed, dress, bathe, or toilet self appropriately for age.
• Has disturbance in eating or sleeping patterns.
• Places non-nutritive or inedible objects in mouth (for example, dirt, chalk).

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 XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Acquiring and Using Information''; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Attending and Completing Tasks''; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Interacting and Relating with Others''; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving and Manipulating Objects''; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''; SSR 82–59, Titles II and XVI: Failure To Follow Prescribed Treatment; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, DI 25225.055, DI 23010.001–23010.010, and DI 23010.020.

[13] *See* 20 CFR 416.924b.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062]

Social Security Ruling, SSR 09–8p. Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–8p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Health and physical well-being.'' 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 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 policy 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 ''Health and Physical Well-Being''

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Health and physical well-being.'' 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 *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 functioning or an ''extreme'' limitation in one domain.[9] 20 CFR 416.926a(a).

Policy Interpretation:

General

In the domain of ''Health and physical well-being,'' we consider the cumulative physical effects of physical and mental impairments and their associated treatments on a child's health and functioning. Unlike the other five domains of functional equivalence (which address a child's abilities), this domain does not address typical development and functioning.[10] Rather, the ''Health and physical well-being'' domain addresses how such things as recurrent illness, the side effects of medication, and the need for ongoing treatment affect a child's body; that is, the child's health and sense of physical well-being.[11]

Some physical effects that we consider in this domain can result *directly from a physical or mental impairment(s).* For example:

- Feeling weak, dizzy, agitated, short of breath, fatigued, low in energy, short on stamina, or ''slowed down'' (as with psychomotor retardation),[12] or having local or generalized pain; and

[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, as we explain in this SSR, that domain does not address typical development and functioning.

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

[10] For more information about the other five domains of functional equivalence, *see* the cross-references at the end of this SSR.

[11] In 20 CFR 416.924a(b)(8) and (b)(9), we provide that ''the impact of chronic illness'' and ''effects of treatment'' are ''factors'' we consider when evaluating a child's functioning. The difference between these ''factors'' and the domain of ''Health and physical well-being'' is that the factors address any kind of effect (physical *or* mental) that a child's impairment(s) has on functioning, and we consider those effects at every step in the sequential evaluation process. However, we consider the domain only when determining whether a child's impairment(s) ''functionally equals the listings,'' and the domain addresses only the physical effects of a child's physical or mental impairment(s) (including associated treatment) on a child's overall health.

[12] Most pediatricians and developmental specialists use the term ''psychomotor retardation'' to describe children with some combination of cognitive, communicative, and motor limitations. However, psychiatrists and psychologists use the term in a more restricted sense, to mean the motor effects of psychiatric disorders, such as the slow or limited movement that may be seen in a seriously depressed individual. In our regulation describing this domain (20 CFR 416.926a(l)) and in our mental disorders listings, the term has the same meaning

Continued

• Allergic reactions, recurrent infections, poor growth, bladder or bowel incontinence, changes in weight or eating habits, stomach discomfort, nausea, seizures or convulsive activity, headaches, or insomnia.

These and other physical effects can also be *the consequence of treatment* a child receives. For example:

• *Medications* for physical or mental disorders can cause generalized symptoms, such as fatigue, dizziness, or drowsiness, or more specific problems, such as nausea or weight loss. Certain medications used to treat mental disorders can have indirect physical effects. For example, some medications used to treat attention-deficit/hyperactivity disorder may cause a change in eating habits which may, in turn, limit growth.

• *Therapy* (for example, chemotherapy, multiple surgeries or procedures, chelation, pulmonary cleansing, or nebulizer treatments) can have physical effects, including generalized symptoms, such as weakness, or more specific problems, such as nausea. In addition, periods of therapy can be frequent or time-consuming, require recovery time, or reduce a child's endurance.

There are other considerations in this domain. For example:

• A child who otherwise appears to be functioning appropriately may be doing so because of intensive medical or other care needed to maintain health and physical well-being. We evaluate such medical fragility in this domain.

• Some disorders (for example, cystic fibrosis and asthma) are episodic, with periods of worsening (exacerbation) and improvement (remission). When symptoms and signs fluctuate, we consider the frequency and duration of exacerbations, as well as the extent to which they affect a child's ability to function physically.[13]

In all cases, it is important to remember that the cumulative physical effects of a child's physical or mental impairment(s) can vary in kind and intensity, and can affect each child differently.

As with limitations in any domain, we do not consider a limitation in the domain of ''Health and physical well-being'' unless it results from a medically determinable impairment(s). However, it is unlikely that a child who has a *significant* problem in this domain does not have an impairment(s) that causes the problem. Therefore, if a child has a significant problem in this domain, and there is no evidence of a medically determinable impairment(s) that could be the cause of the limitations, adjudicators should ensure that they have made all necessary attempts to obtain evidence of an impairment(s) and explain any finding that there is no medically determinable impairment(s) to account for the limitations in the determination or decision.

The Difference Between the Domains of ''Health and Physical Well-Being'' and ''Moving About and Manipulating Objects''

In the domain of ''Health and physical well-being,'' we consider the cumulative physical effects of physical and mental impairments and their associated treatments or therapies not addressed in the domain of ''Moving about and manipulating objects.'' We evaluate the problems of children who are physically ill or who manifest physical effects of mental disorders (except for effects on motor functioning). Physical effects, such as pain, weakness, dizziness, nausea, reduced stamina, or recurrent infections, may result from the impairment(s) itself, medication or other treatment, or chronic illness. These effects can determine whether a child feels well enough and has sufficient energy to engage in age-appropriate activities, either alone or with other children.

In the domain of ''Moving about and manipulating objects,'' we consider how well children can move their own bodies and handle things. We evaluate limitations of fine and gross motor movements caused by musculoskeletal and neurological impairments, by other impairments (including mental disorders) that may result in motor limitations, and by medications or other treatments that cause such limitations.[14]

In fact, an impairment(s) may have effects in *both* domains when it affects the child's general physical state *and* fine or gross motor functioning. For example, some medications used to treat impairments that affect motor functioning may have physical effects (such as nausea, headaches, allergic reactions, or insomnia) that sap a child's energy or make the child feel ill. We evaluate these generalized, cumulative effects on the child's overall physical functioning in the domain of ''Health and physical well-being.'' We evaluate any limitations in fine or gross motor functioning in the domain of ''Moving about and manipulating objects.''

Effects in Other Domains

Impairments that affect health and physical well-being can have effects in other domains as well. For example, a child who must frequently miss school because of illness (including the need to go for treatment) may have social limitations that we also evaluate in the domain of ''Interacting and relating with others,'' behavioral manifestations that we evaluate in the domain of ''Caring for yourself,'' or both. In some cases, chronic absence from school may result in limitations we also evaluate in the domain of ''Acquiring and using information.''

Additionally, generalized or localized pain that results from an impairment(s) may interfere with a child's ability to concentrate, an effect that we evaluate in the domain of ''Attending and completing tasks'' and often in the domain of ''Acquiring and using information.'' Pain may also cause a child to be less active socially, an effect that we evaluate in the domain of ''Interacting and relating with others.'' Some medications for physical impairments may affect mental functioning, interfering with a child's ability to pay attention, remember, or follow directions. We consider these effects in the domain of ''Acquiring and using information,'' ''Attending and completing tasks,'' or both depending upon the type of limitation that results. Other medications for physical impairments may cause restlessness, agitation, or anxiety that may affect a child's social functioning (which we evaluate in the domain of ''Interacting and relating with others'') or emotional well-being (which we evaluate in the domain of ''Caring for yourself'').[15]

Therefore, as in any case, we evaluate the effects of a child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. 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

as it does for psychiatrists and psychologists. Because different specialists use the term differently, it is important to read carefully any evidence that uses this term in order to determine how it is being used.

[13] We generally do not consider brief episodes of illness (for example, ear infections) in this domain because they would not meet the duration requirement. However, there are certain impairments, such as immune deficiency diseases, that increase a child's susceptibility to infection or other disorders. In the domain of ''Health and physical well-being,'' we consider such episodes of illness when they are associated with the child's underlying impairment.

[14] For more information about the domain of ''Moving about and manipulating objects,'' *see* SSR 09–6p, Title XVI: Determining Childhood Disability: The Functional Equivalence Domain of ''Moving About and Manipulating Objects.''

[15] Further, a child may also have social difficulties because of a device used for treatment or assistance in functioning, such as the need to use a breathing device or other adaptive equipment, that results in social stigma.

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

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

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

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

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

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

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

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

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

[18] *See* 20 CFR 416.924b.

SOCIAL SECURITY ADMINISTRATION

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

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

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

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

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

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

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

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

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

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

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

Dated:
February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

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

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

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

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

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

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

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

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