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

FO CODE:

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

MEDICAL RELEASE INFORMATION

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

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

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

A. IDENTIFYING INFORMATION

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

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

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

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

1. Multicentric (not localized or unicentric) Castleman disease

☐ Affecting multiple groups of lymph nodes

☐ Affecting organs containing lymphoid tissue

2. ☐ **Primary central nervous system lymphoma**

3. ☐ **Primary effusion lymphoma**

4. ☐ **Progressive multifocal leukoencephalopathy**

5. ☐ **Pulmonary Kaposi sarcoma**

6. CD4 Count: Absolute CD4 count of 50 cells/mm^3 or less

*Please indicate measurement, date recorded, **AND** ordering provider*

7. CD4 level and BMI or hemoglobin measurements (values do not have to be measured on the same date), with a **and** b.

a. CD4 level

☐ Absolute CD4 count of 200 cells/mm^3 or less

OR

☐ CD4 percentage of less than 14 percent

*Please indicate measurement, date recorded, **AND** ordering provider*

AND

b. BMI or hemoglobin

☐ BMI measurement of less than 18.5

OR

☐ Hemoglobin measurement of less than 8.0 grams per deciliter

*Please indicate measurement, date recorded, **AND** ordering provider*

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

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

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

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

TELEPHONE NUMBER (Include Area Code)

DATE

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

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

FOR OFFICIAL USE ONLY

☐ FIELD OFFICE DISPOSITION:

☐ DISABILITY DETERMINATION SERVICES DISPOSITION:

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED SSA-4814 (Medical Report On Adult With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

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

1. PURPOSE OF THIS FORM:

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

2. WHO MAY COMPLETE THIS FORM:

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

3. MEDICAL RELEASE:

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

4. HOW TO COMPLETE THE FORM:

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

5. HOW TO RETURN THE FORM TO US:

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

Privacy Act Statement
Collection and Use of Personal Information

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

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

1. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office and Department of Veterans Affairs); and,

2. To facilitate statistical research, audit, or investigative activities necessary to ensure the integrity and improvement of our programs (e.g., to the Bureau of the Census and to private entities under contract with us).

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

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

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