SOCIAL SECURITY ADMINISTRATIVE
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0660

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITES (MENTAL)

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

INSTRUCTIONS:

Please assist us in determining this individual's ability to do work-related activities on a sustained basis. "Sustained basis" means the ability to perform work-related activities eight hours a day for five days a week, or an equivalent work schedule. (SSR 96-8p). Please give us your professional opinion of what the individual can still do despite his/her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings, diagnosis, prescribed treatment and response, and prognosis.

For each activity shown below:

(1) Respond to the questions about the individual's ability to perform the activity. When doing so, use the following definitions for the rating terms:

- None – Absent or minimal limitations. If limitations are present they are transient and/or expectable reactions to psychological stresses.
- Slight – There is some mild limitations in this area, but the individual can generally function well.
- Moderate – There is moderate limitations in this area, but the individual is still able to function satisfactorily.
- Marked – There is serious limitation in this area. The ability to function is severely limited, but not precluded.
- Extreme – There is major limitation in this area. There is no useful ability to function in this area.

(2) Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT, WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

(1) Is ability to understand, remember, and carry out instructions affected by the impairment? ☐ No ☐ Yes
If "no", go to question #2. If "yes", please check the appropriate block to describe the individual's restrictions for the following work-related mental activities.

	None	Slight	Moderate	Marked	Extreme
Understand and remember short, simple instructions.	☐	☐	☐	☐	☐
Carry out short, simple instructions.	☐	☐	☐	☐	☐
Understand and remember detailed instructions.	☐	☐	☐	☐	☐
Carry out detailed instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐

What medical/clinical finding(s) support this assessment?

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(2) Is ability to respond appropriately to supervision, co-workers, and work pressures in a work setting affected by the impairment? ☐ No ☐ Yes

If "no", go to question #3. If "yes", please check the appropriate block to describe the individual's restriction for the following work-related mental activities.

	None	Slight	Moderate	Marked	Extreme
Interact appropriately with the public.	☐	☐	☐	☐	☐
Interact appropriately with supervisor(s).	☐	☐	☐	☐	☐
Interact appropriately with co-workers.	☐	☐	☐	☐	☐
Respond appropriately to work pressures in a usual work setting.	☐	☐	☐	☐	☐
Respond appropriately to changes in a routine work setting.	☐	☐	☐	☐	☐

What supports this assessment?

(3) Are any other capabilities affected by the impairment? ☐ No ☐ Yes

If "yes", please identify the capability and describe how it is affected.

Capability	Effect

What medical/clinical findings support this assessment?

(4) If the claimant's impairment(s) include alcohol and/or substance abuse, do these impairments contribute to any of the claimant's limitations as set forth above? If so, please list the specific limitations caused.

(5) If you have concluded that the medical record indicates that the claimant's alcohol and/or substance use/abuse contributes to any limitations set forth above, please identify and explain what changes you would make to your answers if the claimant was totally abstinent from alcohol and/or substance use/abuse.

(6) Can the individual manage benefits in his/her own best interest? ☐ No ☐ Yes

Physician's/Psychologist's Signature	**Medical Specialty**	**Date**

PRIVACY ACT STATEMENT:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information 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.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT:

This information collection meets the clearance requirements of 44 U.S.C. 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 15 minutes to read the instructions, gather the necessary facts, and answer the questions.