

Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change, is consistent with the Act. Comments may be submitted by any of the following methods:

Electronic Comments

- Use the Commission's Internet comment form (<http://www.sec.gov/rules/sro.shtml>); or
- Send an e-mail to rule-comments@sec.gov. Please include File Number SR-NASDAQ-2009-004 on the subject line.

Paper Comments

- Send paper comments in triplicate to Elizabeth M. Murphy, Secretary, Commission, 100 F Street, NE., Washington, DC 20549-1090. All submissions should refer to File Number SR-NASDAQ-2009-004. This file number should be included on the subject line if e-mail is used. To help the Commission process and review your comments more efficiently, please use only one method. The Commission will post all comments on the Commission's Internet Web site (<http://www.sec.gov/rules/sro.shtml>). Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room on official business days between the hours of 10 a.m. and 3 p.m. Copies of such filing also will be available for inspection and copying at the principal office of the Exchange. All comments received will be posted without change; the Commission does not edit personal identifying information from submissions. You should submit only information that you wish to make available publicly.

All submissions should refer to File Number SR-NASDAQ-2009-004 and should be submitted on or before March 11, 2009.

For the Commission, by the Division of Trading and Markets, pursuant to delegated authority.¹³

Florence E. Harmon,

Deputy Secretary.

[FR Doc. E9-3484 Filed 2-17-09; 8:45 am]

BILLING CODE 8011-01-P

SMALL BUSINESS ADMINISTRATION

[Disaster Declaration # 11651]

Oregon Disaster # OR-00027 Declaration of Economic Injury

AGENCY: U.S. Small Business Administration.

ACTION: Notice.

SUMMARY: This is a notice of an Economic Injury Disaster Loan (EIDL) declaration for the State of Oregon, dated 02/11/2009.

Incident: Severe Winter Storm System.

Incident Period: 12/14/2008 through 01/04/2009.

DATES: *Effective Date:* 02/11/2009.

EIDL Loan Application Deadline Date: 11/12/2009.

ADDRESSES: Submit completed loan applications to: U.S. Small Business Administration, Processing and Disbursement Center, 14925 Kingsport Road, Fort Worth, TX 76155.

FOR FURTHER INFORMATION CONTACT: A. Escobar, Office of Disaster Assistance, U.S. Small Business Administration, 409 3rd Street, SW., Suite 6050, Washington, DC 20416.

SUPPLEMENTARY INFORMATION: Notice is hereby given that as a result of the Administrator's EIDL declaration, applications for economic injury disaster loans may be filed at the address listed above or other locally announced locations.

The following areas have been determined to be adversely affected by the disaster:

Primary Counties:

Columbia, Hood River, Multnomah, Washington.

Contiguous Counties:

Oregon: Clackamas, Clatsop, Tillamook, Wasco, Yamhill.

Washington: Clark, Cowlitz, Klickitat, Skamania, Wahkiakum.

The Interest Rate is: 4.000.

The number assigned to this disaster for economic injury is 116510.

The States which received an EIDL Declaration # are Oregon, Washington.

(Catalog of Federal Domestic Assistance Number 59002)

Darryl K. Hairston,

Acting Administrator.

[FR Doc. E9-3404 Filed 2-17-09; 8:45 am]

BILLING CODE 8025-01-P

SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA-2008-0062]

Social Security Ruling, SSR 09-2p.; Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09-2p. This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about documenting and evaluating evidence of a child's impairment-related limitations and related issues.

DATES: *Effective Date:* March 20, 2009

FOR FURTHER INFORMATION CONTACT: Robin Doyle, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235-6401, (410) 966-2771.

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.)

¹³ 17 CFR 200.30-3(a)(12).

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling

Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations

Purpose: This SSR provides policy interpretations and consolidates information from our regulations, training materials, and question-and-answer documents about documenting and evaluating evidence of a child's impairment-related limitations and related issues.

Citations (Authority): Sections 1614(a)(3) and 1614(a)(4) 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, 416.912, 416.913, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child¹ 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 impairments³ 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).

This SSR explains the evidence we need to document a child's impairment-related limitations, the sources of evidence we commonly see in

childhood disability cases, how we consider the evidence we receive from early intervention and school programs (including special education), how we address inconsistencies in the evidence, and other issues related to the development of evidence about functioning.¹⁰

Policy Interpretation

I. General

We use evidence of a child's functioning to determine whether the child's medically determinable impairment(s):

- Is "severe"—that is, causes more than minimal functional limitations (20 CFR 416.924(c));
- Meets or medically equals a listed impairment when the listing criteria include functioning (20 CFR 416.924a(b)(1)); and
- Functionally equals the listings (20 CFR 416.926a).

When we consider functioning in children, we evaluate how the impairment(s) affects the ability to function age-appropriately. A child functions age-appropriately when initiating, sustaining, and completing age-appropriate activities. "Functioning" includes everything a child does throughout a day at home, at school, and in the community. Examples include, getting dressed for school, cooperating with caregivers, playing with friends, and doing class assignments.

As we explain in Section III below, evidence of a child's functioning can come from a wide variety of sources. We will consider all of the relevant evidence we receive about a child's functioning to help us understand how the impairment(s) affects the child's day-to-day activities.

II. What Evidence Do We Need About a Child's Impairment-Related Limitations?

We need evidence that is sufficient to evaluate a child's limitations on a longitudinal basis; that is, over time. This evidence will help us answer the following questions about whether the child's impairment(s) affects day-to-day functioning and whether the child's activities are typical of other children of the same age who do not have impairments. Accordingly, we need evidence to help us determine the following:

- What activities is the child able to perform?
- What activities is the child not able to perform?

¹⁰ For more information about the domains, see the cross-references at the end of this SSR.

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.

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."

⁹ See 20 CFR 416.926a(e) for definitions of the terms "marked" and "extreme."

- Which of the child's activities are limited or restricted compared to other children of the same age who do not have impairments?
- Where does the child have difficulty with activities—at home, in childcare, at school, or in the community?
- Does the child have difficulty independently initiating, sustaining, or completing activities?
- What kind and how much help does the child need to do activities, and how often does the child need it?
- Does the child need a structured or supportive setting, what type of structure or support does the child need, and how often does the child need it?

We do not require our adjudicators to provide formal answers to these specific questions in the determination or decision. However, the evidence should create a clear picture of the child's functioning in the context of the six functional equivalence domains so that we can determine the severity of limitation in each domain. The critical element in evaluating the severity of a child's limitations is how appropriately, effectively, and independently the child performs age-appropriate activities.

Also, a child who is having significant but unexplained problems may have an impairment(s) that has not yet been diagnosed, or may have a diagnosed impairment(s) for which we lack evidence. For example, children who are many grades behind in school often have a medically determinable impairment(s). In many cases, the school will have evaluated the child, and the school records will provide information about whether there is a medically determinable impairment(s).¹¹ It may be necessary to further develop information from the child's medical source(s) or purchase a consultative examination (CE). Adjudicators should pursue indications that an impairment(s) may be present if that fact may be material to the determination or decision.

III. Sources of Evidence About a Child's Impairment-Related Limitations

Once we have evidence from an acceptable medical source¹² that

¹¹ This will be especially true in cases in which the child is behind in school because of mental retardation, borderline intellectual functioning, or a learning disability, which can be established by evidence from a school psychologist, or because of a language disorder, which can be established by a qualified speech-language pathologist. See 20 CFR 416.913(a). However, school records may include evidence from other kinds of acceptable medical sources establishing the existence of a medically determinable impairment.

¹² The term "acceptable medical source" is defined in 20 CFR 416.902 as "one of the sources

establishes the existence of at least one medically determinable impairment, we consider all relevant evidence in the case record to determine whether a child is disabled. This evidence may come from acceptable medical sources and from a wide variety of "other sources."¹³

Medical Sources: Acceptable medical sources can provide information about how an impairment(s) affects a child's everyday activities. For example, a pediatrician might discuss the impact of asthma on a child's participation in physical activities, or a speech-language pathologist might discuss how a language disorder contributes to limited attention and problems in school.

We cannot use evidence from other medical sources who are not "acceptable medical sources" to establish that a child has a medically determinable impairment. However, we can use evidence from these sources, such as nurse-practitioners, physicians' assistants, naturopaths, chiropractors, audiologists, occupational therapists (OTs), physical therapists (PTs), and psychiatric social workers (PSWs), to determine the severity of the impairment(s) and how it affects the child's ability to function compared to children of the same age who do not have impairments. For example:

- A PSW might comment on the child's ability to handle stressful situations.
- An OT or PT may evaluate the impact of a musculoskeletal disorder on the child's activities and comment on muscle tone and strength and how it affects the child's ability to walk with a brace.
- An OT might comment on the child's ability to use motor skills to get dressed without assistance.

Non-Medical Sources: Evidence from other sources who are not medical sources and who know and have contact with the child can also be very important to our understanding of the severity of a child's impairment(s) and how it affects day-to-day functioning. These sources include parents and

described in 416.913(a) who provides evidence about your impairments."

¹³ We explain what the term "other sources" means in 20 CFR 416.913(d). For more information about how we consider opinion evidence from "other sources," including opinions about functional limitations, see SSR 06-03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies, 71 FR 45593 (2006), available at: http://www.socialsecurity.gov/OP_Home/rulings/di/01/SSR2006-03-di-01.html. For information about how we consider opinion evidence from acceptable medical sources, see generally 20 CFR 416.927.

caregivers, educational personnel (for example, teachers, early intervention team members, counselors, developmental center workers, and daycare center workers), public and private social welfare agency personnel, and others (for example, siblings, friends, neighbors, and clergy).

Therefore, we will consider evidence from such non-medical sources when we determine the severity of the child's impairment(s) and how the child typically functions compared to children of the same age who do not have impairments.

IV. Early Intervention and School Programs¹⁴

In most cases, early intervention (EI) and school programs are significant sources of evidence about a child's impairment-related limitations. Children from birth to the attainment of age 3 may receive EI services if they are experiencing delays in one or more developmental areas or if they have a diagnosed physical or mental condition that is likely to result in such delays.¹⁵ Children from ages 3 through 5 may attend preschool or other daycare programs. Children age 6 and older usually attend school and may receive special education and related services¹⁶ if they require specially designed instruction because of their unique needs related to a physical or mental impairment(s).

We require adjudicators to try to get EI and school records whenever they are needed to make a determination or decision regarding a child's disability. We do not require information from EI or school personnel in every case because sometimes we can decide that a child is disabled without it, such as when the child's impairment(s) meets the requirements of a listing. We may also have to make a determination or decision without EI or school evidence when we are unable to obtain it.

¹⁴ School programs also include preschool programs, such as Early Head Start (for children birth to age 3) and Head Start (ages 3 through 5).

¹⁵ EI services may include occupational therapy, physical therapy, speech therapy, psychological services, audiology, health services, nutrition services, nursing services, and assistive technology devices. The developmental areas are: Cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development.

¹⁶ "Related services" includes transportation and such developmental, corrective, and other supportive services (such as physical and occupational therapy) as are required to assist a child with a disability to benefit from special education. A child who does not qualify for special education may qualify for related services under section 504 of the Rehabilitation Act of 1973 to ensure a free, appropriate public education. See section IV.C., below.

A. Comprehensive Evaluations in EI or School Programs

We will consider the results of comprehensive evaluations we receive. Children receive comprehensive evaluations when they are candidates for EI or special education and related services and periodically after that when they receive these services. These evaluations are usually conducted by a team of qualified personnel¹⁷ who can assess a child in all areas of suspected delay or educational need.

As part of a comprehensive evaluation, the EI or school program will use a variety of assessment procedures and tools to identify a child's unique strengths and needs, as well as all of the services appropriate to address those needs. For younger children, the primary focus of the evaluation is their level of functioning in terms of developmental milestones. For school-age children, the primary focus is their level of academic skills and related developmental needs.

The evaluation generally includes:

- Observations of the child in a learning environment or a natural setting, such as in the home;
- Alternative and informal assessments, such as play-based assessment and review of completed classroom assignments;
- Interviews with parents, teachers, or other appropriate people, including child behavior checklists; and
- Standardized tests, such as a formal development test for a toddler or a formal intelligence or language test for an older child.

When we request information from EI programs or schools, we will ask for the most recent comprehensive evaluation and test results, as well as other evidence that supports the analysis of the child's development or academic skills and related developmental needs. Some children may have received a comprehensive evaluation, but may not be receiving EI or special education services. Therefore, we will request this information even if a child is not receiving services.

B. Individualized Family Service Plans and Individualized Education Programs

The agency providing EI services or special education and related services will develop a written plan documenting the child's eligibility for services, the therapeutic or educational

goals, the services the agency will provide, and the setting(s) where the agency will provide these services. Infants and toddlers should have an Individualized Family Service Plan (IFSP). Preschool and school-age children should have an Individualized Education Program (IEP), including an IEP transition plan for children beginning at age 14.

Both IFSPs and IEPs are important sources of specific information about a child's abilities and impairment-related limitations, and provide valuable information about the various kinds and levels of support a child receives. For example, an IEP will describe:

- Supplementary aids and services, such as speech-language pathology services, counseling, transportation, and orientation and mobility services;
- Modifications to the academic program made to accommodate the child's impairment(s), such as reading instruction in a resource room;
- The role of a classroom aide assigned to the child, such as assistance in moving from one classroom to the next; and
- The characteristics of the child's self-contained classroom, such as teacher-student ratio.

This information about supports children receive can be critical to determining the extent to which their impairments compromise their ability to independently initiate, sustain, and complete activities. In general, if a child needs a person, a structured or supportive setting, medication, treatment, or a device to improve or enable functioning, the child will not be as independent as same-aged peers who do not have impairments. We will generally find that such a child has a limitation, even if the child is functioning well with the help or support. The more help or support of any kind that a child receives beyond what would be expected for children the same age without impairments, the less independently the child functions, and the more severe we will find the limitation to be.¹⁸

1. *Present Level of Development or Educational Performance.* The first part of an IFSP or IEP describes and analyzes the child's present level of development (for example, physical or cognitive development) or academic skills based on the comprehensive evaluation or subsequent assessments and other information that is available at the time the IFSP or IEP is developed.¹⁹

2. *Goals and Objectives.* The second part of an IFSP or IEP consists of one or more sets of goals and specific objectives for the infant or toddler's development or the preschool or school-age child's education. The IFSP or IEP includes goals for improvement within 3–6 months (for infants and toddlers) or 1 year for preschool and school-age children. We can infer how the child is currently functioning from these goals. For example, if an IEP goal is "will be able to read at a 4th grade level," we can reasonably conclude that the child was not performing at that level when the IEP was written.

Based on broad developmental or educational goals, the written plan will outline specific objectives organized around the discrete physical or mental skills that must be mastered in order to achieve the goal. The plan also includes the kinds of activities and tasks the teacher or therapist will undertake with the child to develop the targeted skills. For example:

- An IFSP goal for a toddler from an occupational therapist might be: "The child will use fine/gross motor skills to handle age-appropriate materials during play," while a specific objective (one of many) would identify the skills to be developed (for example, articulation of the thumb and all fingers for grasping) and the particular manipulative tasks to be used to develop the needed skills (for example, molding modeling clay into balls).
- An IEP goal for an 11-year-old from a special educator might be: "The child will independently read simple stories at the 4th grade level," while a specific objective (one of many) would identify the skills to be developed (for example, use of phonetic cues to identify initial, medial, and ending sounds in new words), and the particular instruction methods to be used to develop the needed skills (for example, small group instruction with practice sounding out unfamiliar words).

Children who reach age 14 begin the transition from high school to the adult workplace. The IEP transition plan describes a student's levels of functioning based on reasonable estimates by both the student and the special education team and identifies the kinds of vocational and living skills the child needs to develop in order to move into adulthood. The IEP transition goals may range from the development of skills appropriate to supervised and supported work and living settings to those needed in independent work and living situations.

therefore, may indicate that there is other relevant evidence available.

¹⁷ The evaluation team may include personnel who are "acceptable medical sources" under our rules. When the team includes such people, the comprehensive evaluation may provide the primary evidence we need to both establish and evaluate the child's impairment and resulting limitations.

¹⁸ See generally 20 CFR 416.924a(b). See also SSR 09–1p.

¹⁹ IFSPs and IEPs frequently reference underlying psychological or developmental testing, and

Both the IFSP and IEP can provide useful information about a child's functioning. However, the underlying purpose of these documents is not to determine disability under our rules. Rather, the IFSP or IEP is used to design the individualized services and supports a child needs to maximize growth and development or to participate in and progress in the general education curriculum. In contrast, we use the information in the IFSP or IEP to help determine if the child has marked and severe functional limitations.

It is important to remember, therefore, that the goals in an IFSP or IEP are frequently set at a level that the child can readily achieve to foster a sense of accomplishment. Those goals are frequently lower than what would be expected of a child the same age without impairments. In this regard:

- A child who achieves a goal may still have limitations. The child may have achieved the goal simply because it was set low, and may be developing or acquiring skills at a slower rate than children the same age without impairments.

- On the other hand, the fact that the child does not achieve a goal is likely an indication of the severity of the child's impairment-related limitations. However, the child's failure to achieve a goal does not, by itself, establish that the impairment(s) functionally equals the listings.

Therefore, we must consider the purpose of the goals provided in an IFSP or IEP. And, as with any single piece of evidence, we will consider facts, such as whether a child achieves goals in an IFSP or IEP, along with other relevant information in the case record.

3. *Services, Settings, and Supports.* The third part of the IFSP or IEP documents what services the child needs, the settings in which the services will be provided, and any supports the child needs. The services needed may include special education placement, early intervention services, related services (such as occupational therapy, counseling, and transportation services), and supplementary services (such as peer tutoring and a one-on-one aide). The settings for services may include any setting that is typical for the child's same-aged peers and classroom placement (described in a. below). The supports a child needs may include adaptive equipment (such as a special seat), assistive technology (such as a communication board), and accommodations (described in b. below).

The IFSP may have an additional section for "other services," which

outlines services that the child may be receiving from other sources. An EI program should coordinate the services a child needs with other State and Federal programs. If the IFSP identifies such services, we will request the information from the other programs unless we determine that the additional information would not affect the outcome of the case given the other evidence already in the record.

a. Classroom Placements

When a child receives special education services under an IEP, the IEP will include information about the setting where the child will receive the services. There is a continuum of alternative placements including, but not limited to:

- Regular classrooms,
- Regular classrooms with "pull-out" services, such as a resource room,
- Special education classrooms,
- Alternative schools,
- Day treatment programs, and
- Residential schools.

The decision to provide services in a particular setting may be based on factors other than the severity of the child's limitations. Therefore, details about the child's performance in school and other settings (for example, how well the child is performing) are important components of our analysis. As we explain in more detail in SSR 09–1p, we will consider the kinds and levels of the support the child receives.

b. Accommodations

Some students with impairments need accommodations in their educational program in order to participate in the general curriculum. In this context, accommodations are practices and procedures that allow a child to complete the same assignment or test as other students, but with a change in:

- *Presentation*, or how instruction or directions are delivered (for example, read orally to the child by an adult, or provided in large print, on audiotape, or via a screen reader).
- *Response*, or how the student solves problems or completes assignments (for example, using an augmentative communication device or dictating answers to a scribe).
- *Setting*, or how the environment is set up (for example, seating the child near the teacher or seating the child away from distractions).
- *Timing/Scheduling*, or the time period during which the lesson or assignment is scheduled (for example, allowing extra time to complete an assignment or scheduling tests around a child's medication regimen).

C. Section 504 Plans

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the basis of disability in programs and activities that receive Federal financial assistance.²⁰ Schools must provide a free, appropriate public education to each student with a disability.²¹ Children must receive educational and related aids and services that are designed to meet their educational needs, even if they are not provided any special education services under the Individuals with Disabilities Education Act (IDEA).²² Schools will conduct an evaluation of specific areas of educational need for children who have disabilities that limit their access to the educational setting. If a child is qualified under section 504, the school will have a written plan for the aids, services, and accommodations that will be provided. We will consider any section 504 plans when we request information from a child's school.

V. *Standard of Comparison*

Because we compare a child's functioning to the functioning of other children the same age who do not have impairments, we should understand the standard of comparison used by sources of the information. For example, a special education teacher may say a child is "doing well." Without knowing the standard of comparison, this could mean:

- Compared to that teacher's expectations for the child,
- Compared to other children in the special education class, or
- Compared to children the same age who do not have impairments.

Therefore, the adjudicator will consider both the standards used by the teacher or other source to rate the quality of the child's functioning and the characteristics of the group to whom the child is being compared. 20 CFR 416.924a(b)(3)(ii).

VI. *Resolving Inconsistencies in the Evidence*

Adjudicators should analyze and evaluate relevant evidence for consistency, and resolve any

²⁰ Public Law 93–112, section 504; 29 U.S.C. 794(a), as amended.

²¹ See 34 CFR 104.33(a). "Appropriate" in this context means the provision of regular or special education and related aids and services that (i) are designed to meet individual educational needs of handicapped persons as adequately as the needs of nonhandicapped persons are met and (ii) are based upon adherence to procedures that satisfy the requirements of the Department of Education's regulations. 34 CFR 104.33(b).

²² 20 U.S.C. 1400, *et seq.*

inconsistencies that need to be resolved.²³

After reviewing all of the relevant evidence, we determine whether there is sufficient evidence to make a finding about disability. "All of the relevant evidence" means:

- The relevant objective medical evidence and other relevant evidence from medical sources;
- Relevant information from other sources, such as school teachers, family members, or friends;
- The claimant's statements (including statements from the child's parent(s) or other caregivers); and
- Any other relevant evidence in the case record, including how the child functions over time and across settings.

If there is sufficient evidence and there are no inconsistencies in the case record, we will make a determination or decision. However, the fact that there is an inconsistency in the evidence does not automatically mean that we need to request additional evidence, or that we cannot make a determination or decision. Often, we will be able to resolve the issue with the evidence in the case record because most of the evidence or the most probative evidence outweighs the inconsistent evidence and additional information would not change the determination or decision.

Sometimes an inconsistency may not be "material"; that is, it may not have any effect on the outcome of the case or on any of the major findings. Obviously, an inconsistency would be immaterial if the decision would be fully favorable regardless of the resolution. For example, if one piece of evidence shows the child's birth weight as 950 grams and another shows it as 1025 grams, the inconsistency is not material because we would find that the child's impairment(s) functionally equals the listings under 20 CFR 416.926a(m)(6) based on either birth weight. Similarly, an inconsistency could also be immaterial in an unfavorable determination or decision when resolution of the inconsistency would not affect the outcome. This could occur, for example, if there is inconsistent evidence about a limitation in an activity, but no evidence supporting a rating of "marked" limitation of a relevant domain.

At other times, an apparent inconsistency may not be a true inconsistency. For example, the record

for a child with attention-deficit/hyperactivity disorder (AD/HD) may include good, longitudinal evidence of hyperactivity at home and in the classroom, but show a lack of hyperactivity during a CE. While this may appear to be an inconsistency, it is a well-known clinical phenomenon that children with some impairments (for example, AD/HD) may be calmer, less inattentive, or less out-of-control in a novel or one-to-one setting, such as a CE. See 20 CFR 416.924a(b)(6).²⁴

In some cases, the longitudinal history may reveal sudden, negative changes in the child's functioning; for example, a child who previously did well in school suddenly begins to fail. In these situations, we should try to ascertain the reason for these changes whenever they are material to the decision.

In all other cases in which the evidence is insufficient, including when a material inconsistency exists that we cannot resolve based on an evaluation of all of the relevant evidence in the case record, we will try to complete the record by requesting additional or clarifying information.²⁵

Effective Date: This SSR is effective on March 20, 2009.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The "Whole Child" Approach; 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

²⁴ This example highlights the importance of getting a full picture of the "whole child" and of our longstanding policy that we must consider each piece of evidence in the context of the remainder of the case record. Accepting the observation of the child's behavior or performance in an unusual setting, like a CE, without considering the rest of the evidence could lead to an erroneous conclusion about the child's overall functioning.

²⁵ With respect to testing, we provide in 20 CFR 416.926a(b)(4)(iii) that we will try to resolve material inconsistencies between test scores and other information in the case record. We explain that, while it is our responsibility to resolve any material inconsistencies, the interpretation of a test is "primarily the responsibility of the psychologist or other professional who administered the test." If necessary, we may recontact the professional who administered the test for further clarification.

However, we may also resolve an inconsistency with other information in the case record, by questioning other people who can provide us with information about a child's day-to-day functioning, or by purchasing a consultative examination. This regulation also provides that when we do not believe that a test score accurately indicates a child's abilities, we will document our reasons for not accepting the score in the case record, or in the decision at the administrative law judge hearing and Appeals Council levels (when the Appeals Council makes a decision).

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"; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Health and Physical Well-Being"; SSR 06–03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies; and Program Operations Manual System (POMS) DI 24515.055, DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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SOCIAL SECURITY ADMINISTRATION

[Docket No. SSA–2008–0062, Social Security Ruling, SSR 09–4p.]

Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of "Attending and Completing Tasks"

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

SUMMARY: We are giving notice of SSR 09–4p. This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of "Attending and completing tasks." It also explains our policy about that domain.

DATES: *Effective Date:* March 20, 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

²³ This basic policy is also contained in other rules on evidence, including 20 CFR 416.912, 416.913, 416.924a(a), 416.927, and 416.929. For our rules on how we consider test results, see also section 112.00D of the listings for IQ and other tests related to mental disorders, and 20 CFR 416.924a(a)(1)(ii) and 416.926a(b)(4) for all testing.