SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (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, 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 expected reactions to psychological stresses.
- Mild - There is a slight limitation in this area, but the individual can generally function well.
- Moderate - There is more than a slight limitation in this area but the individual is still able to function satisfactorily.
- Marked - There is serious limitation in this area. There is a substantial loss in the ability to effectively function.
- Extreme - There is major limitation in this area. There is no useful ability to function in this area.

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 restriction for the following work-related mental activities.

	None	Mild	Moderate	Marked	Extreme
Understand and remember simple instructions.	☐	☐	☐	☐	☐
Carry out simple instructions.	☐	☐	☐	☐	☐
The ability to make judgments on simple work-related decisions.	☐	☐	☐	☐	☐
Understand and remember complex instructions.	☐	☐	☐	☐	☐
Carry out complex instructions.	☐	☐	☐	☐	☐
The ability to make judgments on complex work-related decisions.	☐	☐	☐	☐	☐

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

(2) Is ability to interact appropriately with supervision, co-workers, and the public, as well as respond to changes in the routine work setting, affected by impairments? ☐ 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	Mild	Moderate	Marked	Extreme
Interact appropriately with the public.	☐	☐	☐	☐	☐
Interact appropriately with supervisor(s).	☐	☐	☐	☐	☐
Interact appropriately with co-workers.	☐	☐	☐	☐	☐
Respond appropriately to usual work situations and to changes in a routine work setting.	☐	☐	☐	☐	☐

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

(3) Are any other capabilities affected by the impairment? ☐ **No** ☐ **Yes**
If "yes," please identify the capability and describe how it is affected.

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

(4) The limitations above are assumed to be your opinion regarding current limitations only.

However, if you have sufficient information to form an opinion within a reasonable degree of medical or psychological probability as to past limitations, on what date were the limitations your found above first present?_____

(5) 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 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

Signature **Date**

Print Name, Title and Medical Specialty (Legibly Please)

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 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 do not need 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. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimorem MD 21234-6401.* **Send only comments relating to our time estimate to this address, not the completed form.**