

# Documenting Disability

## *Simple Strategies for Medical Providers*

by

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Health Care for the Homeless  
Clinicians' Network

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## LETTER I

November 12, 2004

Re: L J

SS# xxx-xx-xxxx

To Whom It May Concern:

I am writing this letter on behalf of L J, a patient of mine at the Austin Cook County Health Center, in support of her claim for disability. She has been a patient at our health center since 5/99 and my patient since 11/00. She has been seen in the clinic an average of 5 times a year during that time period.

Ms. J had a central nervous system cerebro-vascular accident on July 6, 2004 which has left her with significant persistent deficits in right arm and right leg. Her impairments include the following:

**Gait and Right lower extremity:** She has an unsteady gait that has made her unable to walk safely at a constant rate on a treadmill with the physical therapists. Her therapy goal was to walk on a level treadmill at three miles per hour for 10 minutes. She could not keep herself centered on the treadmill and would have fallen repeatedly had she not been supported by the hand rails. She was unable to walk for more than two minutes at a time. Her right hip flexion strength is 3/5. She steps to the right when trying to walk with her feet in tandem.

**Right upper extremity:** Ms. J is right handed. She carries her right arm in a flexed posture when walking. Her right upper extremity strength is 3/5 in flexion and extension at the elbow, and 3/5 in shoulder abduction. She has mildly reduced rapid alternating movements with her right hand and severely reduced ability to write or sign her name. She also has subjective numbness throughout her right arm and moderately reduced ability to identify objects placed in her right hand. She can not carry anything of significant weight (over 2 pounds) in her right hand.

In my opinion, L J is permanently disabled as a result of her stroke. She meets Social Security listing **11.04** as described in the online Blue Book. She has significant and persistent (over 3 months) disorganization of motor function in 2 extremities (right arm and right leg) resulting in sustained disturbance of gross (inability to carry objects) and dexterous (inability to write) movements or gait and station (her gait is abnormal and unsteady).

L J also meets the functional requirements for a musculoskeletal listing described at section 1.00 of the listings. She requires a walker for distances as short as a single block and cannot sustain effective ambulation. Her use of the right arm is so restricted that she cannot prepare a simple meal or feed herself without assistance.

During an eight-hour work day, L J could stand or walk no more than one hour. She can sit without limitation. She is not limited in the ability to lift with her left arm, but she can lift no more than two pounds with her right arm.

L J has not had a mental evaluation since her stroke, but she has complained of memory loss and an inability to concentrate. If her disability claim cannot be favorably resolved based upon her physical limitations, I would recommend that a neuropsychological evaluation be obtained.

If you have any additional specific questions about her condition, please let me know. I am enclosing copies of my relevant treatment records.

Sincerely,

David Buchanan, MD  
Attending Physician  
John Stroger Hospital of Cook County  
Board Certified in Internal Medicine  
Assistant Professor, Rush University

**11.04 Central nervous system vascular accident.** With one of the following more than 3 months post-vascular accident:

A. Sensory or motor aphasia resulting in ineffective speech or communication; or

B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

*Listing of Impairment cited in the preceding letter  
Source: 2006 SSA Blue Book*

## LETTER 2

February 22, 2006

To Whom It May Concern:

I am writing this letter in regards to Mr. J. S., Case # 111111 and SS# 111-11-1111. This letter is intended to give the Social Security Administration information regarding Mr. S's current status as it relates to his application for SSI. I am currently Mr. S's Treating Source. We have had an ongoing treatment relationship since February 2005. I have also consulted on this case with Mr. S's former therapist George Gilman, LCSW and his Case Manager, Jennifer Alfredson, APSW. Mr. Smith was admitted into the Health Care for the Homeless Case Management Program in August 2005.

Mr. S. is not currently engaging in any Substantial Gainful Activity.

Mr. S. was diagnosed with Bipolar Disorder Type I by myself, Dr. Steven Ortell, in February 2005. Prior to February 2005, Mr. S's mental impairments were undocumented. Mr. S. had been living in the woods, outdoors, since 2002 and was not seeking any treatment for what he described as problems with his thinking. He was engaged by the Health Care for the Homeless – Street Outreach. He agreed to begin seeing a psychiatrist at Health Care for the Homeless' Recovery Behavioral Health Clinic. He also agreed to begin working with the Red Cross Outreach Nurse and was referred to a Safe Haven Shelter.

Mr. S's impairments became clearer once he was staying at Safe Haven, where they have only 8 residents and staff present 24 hours a day. Ms. Alfredson was able to inform this writer about the occurrences at Safe Haven. Mr. S. did not respond appropriately to the supervision at Safe Haven. He did not get along with other residents or the staff and mostly stayed to himself. He had trouble understanding that his situation differed from the other residents. He would become very irritable when comparing his situation to others and would ask why he can't get a bus pass or other things that residents with income had access to. He expressed paranoia about the other residents and the staff. He demonstrated an irritable and labile mood that inhibited his ability meet the expectations of staff in the area of household chores and/or keeping his room in order. Mr. S. demonstrated poor judgment when he had trouble following the rules and was eventually asked to move out due to his chronic non-compliance with the curfew of 10 PM. When Mr. S. left the Safe Haven in September 2005, he went back to living in the woods, outdoors. He was quite upset about the consequence of his poor judgment. I think that Mr. S. does demonstrate a severe impairment.

I think that Mr. S. does meet the criteria listed in the Social Security Blue Book, section **12.04** for Affective Disorders. Mr. S. does have a disturbance of mood, accompanied by partial manic and depressive symptoms. Mr. S. meets the criteria of 12.04 (A) in the following way: Mr. S. has depressive symptoms that were first assessed and documented in February 2005. Mr. S. reported a loss of interest in all activities, a sleep disturbance, feelings of guilt and worthlessness, difficulty concentrating and feeling very paranoid. Mr. S. avoids public transportation due to paranoia and is extremely guarded with Outreach Workers and most other staff that he has come into contact with since being engaged by the Outreach Worker. Mr. S. has also experienced symptoms of mania. Mr. S. has been observed to have pressured speech, flight of ideas, and he is easily distracted. He also gets involved in activities that have negative consequences, such as fighting with people on the streets have led to both injury and incarceration. Again, Mr. S. reports feeling very paranoid. As a result of the previously described impairments, Mr. S. was diagnosed with Bipolar Disorder and has had periods manifested by the full symptomatic picture and currently is characterized by both depressive and manic symptoms.

And, Mr. S. meets the criteria of 12.04 (B) in the following way: Mr. S. evidences a marked restriction of activities of daily living. Most notably, Mr. S. has been unable to maintain a residence since 2002. Since that time, he has been living outdoors in a wooded area on the East side of Milwaukee. Mr. S. does not appropriately care for his personal grooming and hygiene. His appearance is usually odorous, his clothing dirty, and his hair appears dirty and unruly. Mr. S. has not had the opportunity to demonstrate the ability to pay bills, cook, or shop due to his having no income and living outdoors. When Mr. S. was living at Safe Haven from July until September 2005, his grooming and hygiene did improve somewhat. At the Safe Haven, he still did not have the opportunity to cook or shop. Mr. S. also avoids public transportation due to his paranoia, which then causes anxiety.

Mr. S. has marked difficulties in maintaining social functioning. Mr. S. has demonstrated that he is unable to interact appropriately with other individuals. Mr. S. does not have any relationships with any of his family, which includes his father and six living siblings. Mr. S. has referred to working for temp agencies where he would only work for a short time and he asked to not return. Mr. S. often refers to arguing with others and specifically, he is not welcome to visit his girlfriend because the people she stays with will not allow him to come to their home. When Mr. S. has staying at Safe



**12.04 Affective disorders:** Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

**A.** Medically documented persistence, either continuous or intermittent, of one of the following:

1. Depressive syndrome characterized by at least four of the following:

- a. Anhedonia or pervasive loss of interest in almost all activities; or
- b. Appetite disturbance with change in weight; or
- c. Sleep disturbance; or
- d. Psychomotor agitation or retardation; or
- e. Decreased energy; or
- f. Feelings of guilt or worthlessness; or
- g. Difficulty concentrating or thinking; or
- h. Thoughts of suicide; or
- i. Hallucinations, delusions, or paranoid thinking; or

2. Manic syndrome characterized by at least three of the following:

- a. Hyperactivity; or
- b. Pressure of speech; or
- c. Flight of ideas; or
- d. Inflated self-esteem; or
- e. Decreased need for sleep; or
- f. Easy distractibility; or
- g. Involvement in activities that have a high probability of painful consequences which are not recognized; or
- h. Hallucinations, delusions or paranoid thinking; or

3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes);

**AND**

**B.** Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

**OR**

**C.** Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*Listing of Impairment specified in the preceding letter  
Source: June 2006 SSA Blue Book*

### LETTER 3

January 4, 2000

RE: SS# \_\_\_/\_\_\_/\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_

To Whom It May Concern:

I have known Mr. S for the past 15 years, during which time I have cared for this gentleman frequently while working as the Boston Health Care for the Homeless Program's physician at Boston Medical Center, Massachusetts General Hospital, Pine Street Inn Nurses' Clinic, and as a member of the outreach teams serving individuals living on the streets of Boston. His medical and psychiatric issues are very complex, and shadowed in a relatively obscure history (most of his medical charts have either been lost or are unavailable to us).

In my professional opinion, this gentleman is totally disabled and unable to partake in substantial gainful activity. He meets the criteria noted in the Listing of Impairments under both Section **11.08** (Neurology, Spinal Cord and Nerve Root Lesions) and Section **12.02** (Mental, Organic Mental Disorders).

Mr. S's life has been decidedly tragic. He apparently left school in the 8th grade, although the circumstances are unclear. On July 19, 1968, at the age of 17, he sustained severe head trauma with facial fractures, loss of the left eye, and brachial plexus injuries with left arm paralysis and muscle contractions when he was struck by a train. Once again, we have few details about the circumstances surrounding this accident. He apparently was in coma for several weeks, and remained hospitalized for approximately six months. The injuries were substantial and devastating. He sustained severe blunt head trauma that left him with a permanent deformity. His left eye required enucleation, and has been a continual source of purulent drainage and intermittent infections since that time. His brachial plexus was severely compromised, and resulted in paralysis of his left biceps and triceps as well as contraction deformities of the left wrist, PIP, and DIP joints. This brachial plexus injury has also caused considerable vascular compromise, and he has well-documented episodes of recurrent frostbite as well as left hand and arm cellulitis. When last evaluated by the vascular surgeons at Boston Medical Center in December, 1998, the plan was to consider either surgical revision of the arm and vasculature or amputation.

Despite these debilitating injuries, Mr. S apparently attempted to work menial jobs from 1970-1974. He was unable to keep these jobs, although we do not know why. At some point during the rehabilitation from his accident, he began to use alcohol heavily. By 1974, at the age of 23, he became literally homeless and has essentially been living in the shelters or on the streets for the past 25 years.

I have thoroughly reviewed Mr. S's most recent chart at Boston Medical Center, which includes the past two years. He has been seen in the emergency department on at least 45 occasions, generally for grand mal seizures, pancreatitis, frostbite, or cellulitis. The ED visits have a tragic monotony, ending virtually always in his refusal to accept hospital or detox admission and an abrupt departure against medical advice. He rarely remains long enough for diagnostic studies, and I was unable to find documentation of a single EEG during this two-year period (although there are references to "abnormal EEGs in the past"). We have also facilitated multiple admissions to detoxification units for Mr. S through our outreach clinic sites, but he again has rarely been able to tolerate more than 2-3 days in any facility.

It is necessary to sort out his substance abuse issues from his underlying medical problems. While alcohol has been a relapsing and debilitating component of his life in the shelters and on the streets for the past 25 years, his head trauma and the brachial plexus injuries preceded his alcoholism and remain the major reason for his disability:

(1) The severe nerve root and brachial plexus injury have left him with paralysis of the left upper arm and contractions of the musculature of his forearm and hands. The vascular compromise from this injury has resulted in repeated episodes of frostbite and cellulitis, even under conditions of mild exposure with ambient temperatures in the 40s. This significant and persistent disorganization of motor function in the left upper extremity in the setting of his brachial plexus injury meets the primary criteria for disability under Section 11.08 of the Listing of Impairments.

(2) His primary disability is an organic mental disorder, and he meets the criteria listed in Section 12.02 of the Listing of Impairments. His massive head trauma resulted in multiple facial fractures (left orbit, zygoma, maxillary sinus), loss of the left eye, and increased intracranial pressure resulting in prolonged coma and requiring decompression with burr holes. This severe damage to the left frontal lobe is undoubtedly the focus of his seizures and most likely explains his disturbances of mood and his emotional lability with well-documented irritability and explosive outbursts. Alcohol clearly

has lowered his seizure threshold, but cannot explain his entire history of seizures, many of which have come (by his report during several prolonged periods of incarceration) while sober and on Dilantin with adequate serum levels.

Most significantly, a head CT scan in September 1998 showed evidence of old burr holes as well as longstanding encephalomalacia in the left frontal lobe, cerebellar atrophy, and ventricular prominence resulting from volume loss. To be specific, Mr. S easily meets the required level of severity for an organic mental disorder. He demonstrates (A) marked affective changes since his head trauma that predate his use of alcohol and have resulted in mood disturbances and emotional lability that have resulted in (B) marked difficulties in maintaining social functioning (as evidenced by 25 years of homelessness and loss of family and social supports) and repeated episodes of deterioration (as evidenced by his inability to remain in hospital or detoxification facilities).

I hope that this letter has been helpful in assessing this most unfortunate gentleman whose life has been devastated by the head trauma and nerve root injuries he sustained at a young age. In my professional opinion, he is totally disabled. Please feel free to call me anytime with further questions.

Respectfully,

James J. O'Connell, M.D.  
 Boston Health Care for the Homeless Program  
 Departments of Medicine  
 Boston Medical Center and Massachusetts General  
 Hospital

**11.08 Spinal cord or nerve root lesions**, due to any cause with disorganization of motor function as described in 11.04B.

11.04 Central nervous system vascular accident.  
 With one of the following more than 3 months post-vascular accident:

**B.** Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station (see 11.00C).

11.00 Neurological:

**C.** Persistent disorganization of motor function in the form of paresis or paralysis, tremor or other involuntary movements, ataxia and sensory disturbances (any or all of which may be due to cerebral, cerebellar, brain stem, spinal cord, or peripheral nerve dysfunction) which occur singly or in various combinations, frequently provides the sole or partial basis for decision in cases of neurological impairment. The assessment of impairment depends on the degree of interference with locomotion and/or interference with the use of fingers, hands and arms.

*Listing of Impairment specified in the preceding letter  
 Source: 2006 SSA Blue Book*

**12.02 Organic mental disorders:** Psychological or behavioral abnormalities associated with a dysfunction of the brain. History and physical examination or laboratory tests demonstrate the presence of a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities.

The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

**A.** Demonstration of a loss of specific cognitive abilities or affective changes and the medically documented persistence of at least one of the following:

1. Disorientation to time and place; or
2. Memory impairment, either short-term (inability to learn new information), intermediate, or long-term (inability to remember information that was known sometime in the past); or
3. Perceptual or thinking disturbances (e.g., hallucinations, delusions); or
4. Change in personality; or
5. Disturbance in mood; or
6. Emotional lability (e.g., explosive temper outbursts, sudden crying, etc.) and impairment in impulse control; or
7. Loss of measured intellectual ability of at least 15 I.Q. points from premorbid levels or overall impairment index clearly within the severely impaired range on neuropsychological testing, e.g., Luria-Nebraska, Halstead-Reitan, etc;

**AND**

**B.** Resulting in at least two of the following:

1. Marked restriction of activities of daily living; or
2. Marked difficulties in maintaining social functioning; or
3. Marked difficulties in maintaining concentration, persistence, or pace; or
4. Repeated episodes of decompensation, each of extended duration;

**OR**

**C.** Medically documented history of a chronic organic mental disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. Repeated episodes of decompensation, each of extended duration; or
2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

*Listing of Impairment specified in the preceding letter  
 Source: 2006 SSA Blue Book*

## LETTER 4

May \_\_, 2004  
Re: D. A.  
SSN: \_\_\_-\_\_\_-\_\_\_\_  
DOB: \_\_/\_\_/\_\_  
MRN: \_\_\_\_\_

To Whom It May Concern:

I am writing as the primary treating physician of D.A. (DOB \_\_/\_\_/\_\_). I have been treating him since 5/3/02 and seeing him at intervals of 1 week due to the complexity of his medical and mental health conditions. His previous medical care has been received in correctional facilities and at San Francisco General Hospital where he is currently under a court mandated restraining order which prevents him from receiving care there. I have reviewed his extensive past medical records (1993-2002). The following are current active medical problems for this patient:

- 1) Chronic Abdominal Pain: The patient has had multiple abdominal surgeries since childhood. He suffers from chronic pain especially in the left flank and left lower quadrant areas. The pain is constant and unremitting with periodic increases in intensity several times a day. The pain has been attributed to intra-abdominal adhesions which are not amenable to surgical treatment. The pain is also likely related to recurrent kidney stones and extensive past instrumentation of his urinary tract. The patient has a history of left kidney vascular and ureteral malformations which have led to multiple episodes of nephrolithiasis, hydronephrosis, and required multiple surgeries. He has a history of recurrent uric acid kidney stones. He has required high doses of opiate analgesic medication for at least the last 10 years.
- 2) Bilateral Inguinal Hernia: The patient has bilateral inguinal hernias which are awaiting repair. These have been present and causing the patient pain for greater than 1 year. At this time surgical consultation is underway. The hernias are a source of pain and limitation in exertion.
- 3) Degenerative Joint Disease/neuropathic pain: The patient complains of chronic joint pains in his knees and other joints. He has had multiple traumas and accidents and likely has post traumatic arthritis. He also complains of burning/pins and needles type pain in both lower extremities left worse than right. He reports some improvement with gabapentin and indomethacin.
- 4) Asthma and frequent lower respiratory infections: Patient has had 2 episodes of pneumonia in the past 1 year and several episodes in the past and is frequently dyspneic with exertion. He reports some relief with bronchodilatory inhalers.
- 5) Personality Disorder/History of impulsive, violent, and threatening behavior: The patient has a history of multiple traumatic incidents. He has been incarcerated multiple times. His medical treatment has been compromised by the fact that he violently threatened his previous physician who could no longer treat him and obtained a restraining order keeping the patient away from the entire San Francisco General Hospital. The patient feels he has anxiety from traumas which occurred while he was in prison. Professionals who have interacted with him in the past have noted his anti-social behavior and threats of violence. The patient has poor insight into this and feels his behaviors have been misunderstood but it is clear from his history that he has anti-social personality disorder and poses a potential threat in any work or social environment. The patient also has an impulse control disorder and exhibits very poor judgment.
- 6) Substance Abuse: The patient reports previous use of stimulants as his primary problem. He reports previous loss of control of his use of opiate medications. At present he reports he is not using amphetamines, cocaine, heroin, or any other non-prescribed medications. He does not drink alcohol and reports that he is subject to random drug testing as a condition of his parole.
- 7) Hepatitis C Infection: The patient has positive hepatitis C antibody test. Further work up has not been done but his symptoms of fatigue and neuropathy may be attributable to this.

### Physical Exam:

Patient appears stated age, somewhat disheveled with poor grooming  
HEENT: EOMI, PERRLA, fundi nl. mouth and throat nl, poor dentition with multiple missing teeth and caries  
Neck: - adenopathy, - thyromegaly, full ROM

Chest: Exp. wheezes and rhonchi, -rales, - dullness

COR: RRR, S1S2, - murmur, pulses nl.

Abd.: multiple healed surgical scars, diffuse tenderness, - rigidity, - point tenderness, + punch tenderness over left flank, bilat. inguinal hernia reducible with some difficulty and pain

Ext.: +crepittance L knee, full ROM at all joints, - edema

Neuro: alert, oriented x3, CNII-XII nl and symmetrical, strength and sensory nl. and symmetrical

Psych: Patient appears anxious and at times impatient, thought content is predominated by his chronic pain, complex medical history, and anger and frustration that he cannot physically perform his previously normal activities. He is homeless and has minimal social supports, no family support network, no social network. He has not appeared intoxicated or impaired in any encounter. -SI, - HI

Current medical plan: refer patient for surgical repair of bilat hernia, refer patient to comprehensive pain management center (requires Medi-Cal or other medical insurance)

Continue current meds - oxycodone with tylenol 5/325 6/d, indomethacin 25mg 3 bid, gabapentin 300mg 3tid, albuterol inhaler, hydroxyzine 25mg q8hr prn

### **In Summary:**

This unfortunate 40 year old man is currently homeless and socially isolated. His past records and current exam demonstrate long term chronic severe pain. He also has a personality disorder which has caused him to be involved in many violent situations and extensive conflict. In particular this has caused him to be prevented from receiving medical care at the only public hospital in San Francisco. He has a long history of substance abuse but is currently not using drugs. He appears to have some insight into this problem. His ability to respond appropriately to supervisors or co-workers is highly doubtful due to his personality disorder and the poor prognosis for improvement of these types of conditions. It has been felt that his potential to actually commit violent acts is high. Due to chronic pain his concentration and persistence in tasks are very poor. Mr. A's arthritis and lung disease would prevent him from performing a job which required the ability to stand or walk more than two hour in a work day or to lift more than 15 pounds occasionally. If Mr. A follows through with all medical plans he may achieve some general improvement in his functional level but I do not anticipate that even with the maximum expected improvement and continuing abstinence from drugs that he will ever be able to work again. I have attached copies of my relevant treatment records.

Barry Zevin MD  
Internal Medicine  
Medical Director, Homeless and Community Services  
Tom Waddell Health Center

## LETTER 5

May 12, 2004

Re: E. A.

SSN: \_\_\_-\_\_\_-\_\_\_\_\_

DOB: \_\_/\_\_/\_\_

MRN: \_\_\_\_\_

### **Social Security Analyst:**

Mr. \_\_\_\_\_ of the Disability Evaluation Assistance Program referred Mr. E. A. for a medical consultative examination. He was evaluated today in collaboration with Dr. Barry Zevin. Medical records from San Francisco General Hospital and South East Health Center were also used for this report.

Mr. A. was raised in San Francisco. He was a junior high and high school athlete, primarily running track, and playing football and basketball. He left high school in the 12<sup>th</sup> grade to join the job corps and never finished his GED. He states he is quite illiterate. He can read some words and a few sentences in the newspaper, and has trouble spelling. He does not write very well. After high school he worked in a car wash for approximately 10 years and later became a security guard. He only did security for about 6 months when he was forced to quit due to severe knee pain. He worked off and on, the last job was sweeping the streets for SLUG, which he enjoyed but was only able to do for 6 months, again leaving due to too much missed work from the knee pain and progressive hip pain. His last day of work was 9/11/01.

He now complains of bilateral knee pain, bilateral hip avascular necrosis, benign prostatic hypertrophy and some recurrent "distress", with some depression in the last year. His wife of 23 years passed away 1 year ago and he is having great difficulty adjusting. He has 3 grown children whom he sees only occasionally. He is currently on GA and is living with his grandmother. He states his greatest problem is the constant, throbbing and shooting pain he experiences. He complains of great difficulty using public transportation. He can not get on the "kneeling bus" without using both hands and arms to pull him up the stairs. He states he is unable to carry groceries and cannot sweep or vacuum. He is able to stand for short periods of time to do dishes.

### **Medical Problems:**

#### Bilateral hip pain

He describes severe aching and shooting pain in his left hip for the last 3-4 years. He was sent to the orthopedic clinic at SFGH. They performed a left hip core decompression for avascular necrosis on 7/25/03. He continues to have constant pain, 8/10 on a pain scale of 1-10, 10 being the worst possible pain. He is being treated with Tylenol with Codiene #3, two every 4-6 hours without relief. He describes the pain as shooting down the side of his leg, sometimes accompanied by a warm sensation of hot oil going down the front. MRI dated 4/22, 2004 shows core decompression of the left hip with granulation and continued avascular necrosis (AVN). The right is without AVN of the trochanteric head but does show inter-trochanteric necrosis. These conditions are consistent with the amount of pain he is experiencing. Due to a GI bleed he is unable to take NSAID's.

#### Knees

He complains of recurrent, worsening bilateral knee pain. He remembers being told that he needed "knee cap replacement" with a plastic patella. He was afraid of the surgery and did not pursue it. He was diagnosed with patellofemoral syndrome on the left, after the core decompression of his hip. Plain films from January 8, 2004 show bilateral infarcts of the distal diaphysis of the right and left femur and a bony infarct involving the posteromedial left tibia.

#### Left arm radiculopathy

He has left arm numbness and a deep ache. The pain is intermittent and often disturbs his sleep. An MRI is scheduled for July 12, 2004 to further evaluate the cause of the radiculopathy.

#### Low Back Pain

MRI of the lumbar spine dated 4/22/04 showed broad based disk bulges of L3-4, L4-5 and L5-S1. There appears to be mild canal stenosis and the bulges may be touching the L5 and S1 nerve routes.

#### Substance Use

He describes using drugs and alcohol since the age of 13. He became clean and sober 5 years ago and remains so today. He describes the last year being difficult since his wife's death but he is proud of himself for not using drugs.

#### Benign Prostatic Hypertrophy

He has a history of urinary dripping and frequency, which is being followed by a Urologist. He is taking Terazosin 10 mg daily with moderate relief.

**Findings:**

General: Mr. A arrived on time for his appointment. He was clean and well dressed and walked with a cane and a significant broad based limp. He was unable to do the heel to toe walk or walk on his heels and toes without holding on to the walls. He was pleasant and articulate however he had a depressed affect. He seemed somewhat distressed in his speech. He squirmed frequently in his chair and had very frequent spasmodic jerking. He attempted all requested maneuvers with moderate difficulty in carrying them out.

Height: 70", Weight: 164 lbs., B/P sitting (R): 140/82, Pulse: 72

HEENT: Unremarkable

Spine: Tender midline at the lumbosacral area. Decreased range of motion with lateral bending bilaterally, limited by pain and loss of flexibility. He did have positive straight leg raises on the right while supine.

Upper Extremities: Full ROM and strength equal bilaterally.

Cor: Bounding without murmur. Skin is warm and dry.

Pulm: Clear to auscultation, all lobes.

Abd: Liver tender, not enlarged

Lower Extremities: Both knees were painful with flexion. Able to perform a ~ 30° deep knee bend. Crepitus present bilaterally on passive and active range of motion. He had significant hip pain with flexion limited to ~80°/ 110° on the left. There was significant loss of internal and external rotation of the left hip. The right hip was painful with all maneuvers, with moderate generalized limited range of motion.

Neuro:

DTR's	Biceps	Triceps	Patellar	Achilles
Right	I+	I+	I+	0
Left	I+	I+	I+	0

**Summary**

Mr. A is a pleasant 52 year old man. He suffers from significant deep-seated pain in both of his hips and knees as a result of many different disease processes. The progressive nature of the avascular necrosis, intertrochanteric necrosis and bony infarcts in all weight bearing joints, has become almost totally debilitating. Given his long and active athletic and work history, it is evident that he would work if he possibly could. He has made many attempts to maintain work only to have to quit due to the pain and lack of physical endurance. He is still in the process of a workup for his upper extremity radiculopathy.

Observation of him and his physical state during the interview and exam showed him to be in severe discomfort with sitting for even a short period of time. His grimacing and spasmodic jerking from pain were very distracting and obviously debilitating. His broad based gait and limp, assisted by a cane was slow and labored. His depressed / distressed affect could certainly be from the severity of his chronic pain.

I do not believe that Mr. A can sit or stand for more than 15 minutes without the opportunity to alternate position. He cannot walk without the use of a cane. While he holds his cane in his dominant right hand, his use of the left arm/hand is severely restricted by radiculopathy. Although he can use his right hand to lift when in the seated position, he cannot carry even 10 pound weights. He has chronic pain while on a high dose of narcotic medication. His ability to concentrate is severely impaired. His past history of substance use is not material to his case.

If he were to be awarded disability benefits, I believe he would be able to manage his own funds without difficulty. I have enclosed copies of my relevant treatment records.

Sincerely yours,

Masa Rambo, RN, MS, FNP  
 Barry Zevin, MD  
 Diplomate, American Board of Internal Medicine

## CITY AND COUNTY OF SAN FRANCISCO



Department of Public Health  
Homeless Programs  
Tom Waddell Health Center

50 Lech Walesa Street  
San Francisco, CA 94102  
Telephone: (415) 355-7400  
FAX: (415) 355-7407

### LETTER 6

#### Medical Summary [10/04] S.L.

I have followed S. L. as his primary care treating physician since 8/15/03. I have seen him approx. every 6 weeks since that time and at times more frequently. Mr. L. is a 54 year old man who initially presented with a history of mental health problems, alcohol abuse, and a history of back problems and hospitalization for "pneumonia and congestive heart failure." On presentation he was homeless and sleeping on the steps of a church. He was unable to access services due to severe anxiety and shame. He reported a career as a ballet dancer and choreographer both in the United States and Europe. He is currently abstinent from alcohol and seeking psychiatric treatment. His problems and course in summary:

**Bipolar disorder:** the patient was diagnosed with bipolar disorder in New York City several years ago. He reports greater than 20 years of episodic severe depression, alternating with periods of feeling invincible and starting big projects. Symptoms of his disorder include anxiety with severe panic attacks, many losses including failed relationships, lost friendships, homelessness, and severe interference with his career. He reports bulimia and anorexia as symptoms he has struggled with for many years. He reports episodes of using alcohol to blunt his feelings of irritability, depression, and anxiety. Previous treatment had included Valium and ativan. He reports being told that he might need medications to stabilize his mood but never took these nor believed he needed them. Initial attempts at prescribing Valproate (Depakote) to him were unsuccessful due to his perception of side effects. He was referred to a psychiatrist (Dr. Hammond) and psychotherapist at Mission Mental Health Center. He was prescribed anti-psychotic medication but did not adhere well to this. Most recently he has been restarted on Valproate which he has tolerated since he has been abstaining from alcohol. His poor insight and the presence of a co-occurring narcissistic personality style or disorder have complicated his psychiatric care.

**Musculoskeletal complaints:** the patient reports a history of problems with his back, extremities, and "diaphragm" which result from his years as a dancer. He has received various therapies in the past for these and reports he can no longer dance professionally due to his pain but otherwise copes with his chronic pain. He has not requested further work up or treatment of his pain.

**CHF/pneumonia/:** these were apparently acute and resolved problems. There are currently no signs of heart or lung problems.

**Alcoholism:** The patient has a history of drinking in an excessive and uncontrollable manner. He has required several episodes of medically supported detoxification while under my care. He participated in a residential rehab program at Baker Places and was abstinent for 3 months but continued to have severe psychiatric symptoms and relapsed soon after completing the program. He required hospitalization in July 2004 after being assaulted when intoxicated. He had severe alcohol withdrawal at that time and required medical detox. He had a seizure which we have assessed as alcohol related at that time. He has abstained from alcohol since that time and reports he has had 13 years of sobriety between 1989 and 2002 and feels he has the tools to do this again especially if his underlying psychiatric issues are stabilized.

**Multiple somatic complaints:** The patient has had frequent complaints of respiratory, GI, and GU complaints. These do not seem to be caused by any underlying severe disorder but reflect somatization of his underlying psychiatric disorders.

**In Summary:** S. L. has a long history of untreated Bipolar disorder and alcoholism. Observation of him during periods of abstinence strongly suggests that his psychiatric disorder is the primary diagnosis. He has been unable to engage in any Substantial Gainful Activity during the period of time I have been treating him. At times he has embarked on volunteer work or started planning for large projects but has been unable to follow through with these commitments. His insight into the nature of his problems is low. With continued treatment he has a guarded chance of recovery and improvement but I would expect this to require several years of adherence with medications, psychotherapy, and abstinence from alcohol. If Mr. L. were to be awarded benefits I would recommend that he have a payee for money management as his illness has a severe effect on his judgment.

Barry Zevin MD  
Diplomate American Board of Internal Medicine

## CITY AND COUNTY OF SAN FRANCISCO



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## LETTER 7

**Medical Summary Update 2/9/06 S.L.**

This is a follow up to a letter written in 10/04. I have continued to follow this patient as his primary care treating physician. I have seen him at intervals of about monthly and at times weekly. Unfortunately the patient's condition has deteriorated since that time. He has attempted paid or volunteer work a few times in the past year but these have ended quickly due to his inability to maintain psychiatric stability. This will update the patient's problems as outlined in the previous letter:

**Bipolar disorder / narcissistic personality disorder:** The patient has now been taking Divalproex sodium (Depakote) on a regular basis. He has had good adherence and reports the medication helps avoid what he describes as his manic episodes. He still has episodes of severe depression which have triggered relapses to drinking alcohol several times over the past 4 months. He has had less episodes of panic attacks in the past year but continues with occasional (about once a month) very debilitating panic and daily anxiety effecting his ability to function. He has had several referrals and episodes of treatment in the mental health system since the last report. Each of these has ended with patient dissatisfaction and exacerbations of the patient's condition. He has also had conflict and increased stress related to his attempts to return to working as a ballet instructor. He was apparently accused of some type of inappropriate behavior toward a young student. These conflicts and difficulties are consistent with his diagnosis of narcissistic personality disorder. Unfortunately no psychotherapy has been effective as of yet in helping the patient cope with this problem. In the past 6 weeks the patient has had at least 6 emergency room visits due to feelings of severe depression, anxiety, and suicidal behavior or ideations. The patient is socially very isolated at this time and is markedly impaired in this area. He is having a very difficult time keeping up with basic self care. He has markedly impaired concentration, persistence, and pace.

**Musculoskeletal complaints:** The patient continues with complaints of back and joint pain. These seem to be degenerative in nature. They limit him from exercising as he would like to and would likely limit his ability to do exertional work. He has not requested treatment or further diagnostic studies for these problems.

**Alcoholism:** The patient maintained sobriety for greater than 1 year during 2004-2005. He reported no or low amounts of craving except during periods of increased anxiety and depression. In the past 3-4 months he has had several drinking episodes (binges). These have resulted in his depression and anxiety getting worse. We treated his alcoholism with extensive counseling and also tried naltrexone. He does not seem to tolerate the medication well and as of yet he does not seem to be having much benefit. He had one episode in residential medically supported detox. He left before completing the full course of treatment (3 weeks) again related to his narcissistic personality disorder. The relationship of his mental illness to his alcoholism continues to be very strong. His mental health symptoms do not abate during periods of sobriety. These symptoms do become more dangerous when he is drinking as he becomes more impulsive and potentially acts on his suicidal ideations.

**In summary:** The patient's condition has somewhat deteriorated over the past year. The patient meets listings in section 12.04 and 12.08 in the Disability Evaluation Under Social Security. The patient does have a diagnosis of alcoholism and this is of serious concern as outlined above. Observation of the patient during extended periods of sobriety and based on past history indicate that the patient's impairments exist independent of the patient's alcoholism and alcoholism is not material to the patients disability. Please feel free to contact me if I can be of any further assistance.

Barry Zevin MD  
Diplomate American Board of Internal Medicine  
Certified in Addiction Medicine  
American Society of Addiction Medicine

CITY AND COUNTY OF SAN FRANCISCO



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LETTER 8

Medical Summary 2/9/06 V. H.

I have followed V. H. as his primary care treating physician since 8/6/04. I have seen him at intervals of 1 month or more frequently. The patient presented for care with complaints of back pain, pain from inguinal hernia, history of bipolar disorder, and homelessness. The patient perceived himself as quite ill but also expressed the expectation that he would soon be able to return to work. The patient has been an extremely high user of medical services due to physical illness and mental illness. Since 7/04 the patient has had 166 encounters in our health network alone (San Francisco General Hospital and Tom Waddell Health Center). He has had numerous visits at other hospitals and crisis centers which I do not have records of but have been reported by the patient. He has had conflict with staff and has appeared to be threatening and possibly violent at times. Education and redirection toward more appropriate and healthier uses of the healthcare system have not been effective. This likely reflects the seriousness of his mental health disorders. The patient's medical problems include:

**Chronic Back Pain:** The patient complains of severe and intractable pain in his lower back. He reports onset of this pain after an injury in 2000 in which he reports "disc rupture of L4 and L5." Medical records from that time are not available to me. Lumbar spine X-Ray shows rotatory levoscoliosis, osteophytes at the level of L4 through L5, narrowed disc space with vacuum phenomenon seen at the level L5-S1. This is consistent with the patient's history and subjective complaints. He has been treated with NSAIDS which have not been effective. The patient is treated with MS Contin (extended release oral morphine) which has been partially effective for the patient's pain. He has had constipation and some sedation as a side effect. With use of the morphine he is able to sleep more comfortably and ambulate. He still has severe pain with bending or lifting any weight. He is not interested in considering surgical options and has been too unstable to follow up for physical therapy.

**Inguinal hernia recurrent:** The patient has had R and L inguinal hernias and has had at least 3 surgeries in the past year. His post-operative self care has been poor due to his homeless status and poor judgment. He does have pain in both inguinal areas. His ability to stand long periods or walk for extended periods is effected by this pain.

**Asthma/COPD/bronchospasm:** the patient has an extensive smoking history. He is short of breath at times and this is so severe that he must go to the hospital emergency department several times each year. CXR shows increased lung volumes suggestive of COPD. Office spirometry was within predicted range with small improvement after inhaled bronchodilator. The patient uses albuterol and atrovent and steroid inhalers regularly. He may have periodic exacerbations of asthma. His pulmonary symptoms may also be exaggerated by his mental health disorders. Smoking cessation counseling is underway and full PFT's would be beneficial.

**Bipolar Disorder:** The patient reports bipolar disorder initially diagnosed in 1990. He also reports he was "hyper" as a child but it is unclear if this was ever diagnosed or treated. The patient reports a family history that his mother had manic depression and committed suicide in 1988. The patient reports his symptoms as episodes of severe depression and episodes of acting impulsively and with very poor judgment. He reports he did well when prescribed Lithium between 1990 and 1999. He reports stopping because he thought he was better. He has had many losses and problems since that time including loss of his home and jobs. The patient has received treatment at Westside Crisis Clinic and South of Market Mental Health Clinic. He was initially prescribed several medications and reports adherence to them. He has been non-adherent with appointments and follow up and has not been on medications regularly for approximately the past year. At times he has acted in an impulsive manner here in the clinic and staff have felt threatened and that he was capable of being violent. He has not been physically violent in the clinic but has been asked to leave at times.

At times the patient has appeared quite depressed in the clinic. He is often quite irritable and describes episodes that he can not name as irritability but are quite typical of bipolar disorder. He has exhibited grandiosity at times. He has kept most of his appointments and been late at times. His hygiene and self care has ranged from adequate to poor. He has not been able to obtain or maintain housing and usually uses homeless shelters. He expresses high levels of guilt and shame about his condition at times and minimizes and denies his problems at other times. He appears to have few or no friends and no social support system. The patient has marked impairments in his concentration, persistence and pace. In the time

I have been seeing him his condition has somewhat worsened. We continue to redirect him and move him toward obtaining mental health care. He seems overall hopeless that he will be able to benefit at this point from such care.

**Substance Abuse:** The patient initially reported occasional alcohol use and later noted “recreational” cocaine use. He reported that he felt these were not a problem for him. Further evaluation over time indicates the patient does have a substantial problem with stimulant abuse of crack cocaine. He does not appear to drink alcohol regularly and does not appear to abuse opiates or other sedatives. He has never reported to the clinic in an intoxicated state. He has received very extensive counseling from myself and our staff and been offered assistance. The patient appears to have some insight and acceptance of this as a problem which represents progress from his initial presentation. He has not moved toward obtaining treatment and we continue to use motivational enhancement techniques. The patient’s cocaine use clearly exacerbates his underlying medical and psychiatric conditions.

**Somatization and extensive use of medical system:** The patient has had numerous complaints of pain and numerous other symptoms for which he has presented to emergency rooms and urgent care centers. He does not appear to have severe physical problems causing these symptoms but they appear to represent a high degree of anxiety and somatization. Review of these records demonstrates that the patient has not been making these visits as “drug seeking behavior.” He reports to the medical staff that he is receiving opiate medication from his primary care physician and does not ask for additional medicine. The visits appear to be impulsive behavior and help seeking. Efforts to redirect this help seeking to more productive ends have failed thus far but will continue.

### Summary

Mr. H. is an unfortunate 48 year old man with physical and mental health problems. He has severe back pain requiring opiate analgesic treatment. It is likely that the extent of this back pain would prevent him from doing any activities that required more than minimal exertion. He has bipolar disorder which manifests as depression at times and irritability and impulsiveness. He has exhibited very poor judgment. He has had multiple losses and been unable to function adequately to obtain his own housing. He uses crack cocaine which exacerbates his condition. I do not believe the patient has had any extended period clean from drugs during my care of him to evaluate the severity of his impairments without drugs. His health seeking behavior is disordered in a way atypical for patients primarily with stimulant dependence as their diagnosis. His symptoms and behavior are more typical of Bipolar disorder and probably a personality disorder than stimulant abuse alone.

As a physician with extensive experience in addiction medicine it is my best judgment that this patient would have severe impairments even if he were abstinent. The patient’s prognosis for improvement is guarded. His back pain is likely to continue or worsen as he ages. His mental health disorders while treatable are not curable. Poor judgment about the need for adherence to medication is particularly common in bipolar disorder. This patients impairments taken together meet or equal listings in Disability Evaluation Under Social Security. I believe this is the case independent of the patient’s substance abuse. If this patient were awarded benefits I would recommend that he have a mandated payee due to his poor judgment and likely inability to provide minimal food, clothing, and housing for himself.

Please feel free to contact me if I can provide any further information.

Barry Zevin MD  
Diplomate American Board of Internal Medicine  
Certified in Addiction Medicine  
American Society of Addiction Medicine

## LETTER 9

Ms. Jane Jones or Ms. Francine Smith  
Disability Determination Services  
P. O. Box 6338  
Timonium MD 21094-6338

Re: A.P.  
DOB:  
SSN:

Dear Ms. Jones or Ms. Smith:

Ms. A. P. is a 25-year-old, married, Caucasian female who was first hospitalized psychiatrically in August, 1997 and who has had several hospitalizations and day hospital stays since that time. Ms. P. is a soft-spoken, anxious, tall woman of average build. She wears glasses. She is struggling enormously with her illness of schizoaffective disorder and desperately wants, as she states, to be “normal.” She is cooperative with treatment but is easily stressed and, when this happens, she often becomes symptomatic. She needs a great deal of support to maintain herself in the community.

...

### Functional Information

According to Ms. P., a typical day is one in which she gets up at about 8 a.m. and showers. She sometimes eats breakfast. She said that her family assists with cleaning the house. She does clean the cats’ litter boxes and feeds the animals (4 cats and one dog). When she was attending the ADH, her mother-in-law would transport her. She generally watches television during the day. Her husband generally arrives home from work between 4:30-5:00. Her family supplies dinner for Ms. P. and her husband. She goes to bed between 10-10:30 p.m.

Ms. P. experiences significant impairment in her activities of daily living, in her social functioning, and in her ability to complete tasks. She has been unable to work since her release from the Army in 9/97.

Regarding her activities of daily living, in her interview with the SSI Project Director, Ms. P. said that her mother-in-law or her grandmother cooks for her; she said that she doesn’t know how to cook. Earlier in her illness, she had great difficulty talking on the phone and would experience “bad anxiety attacks. I couldn’t sit still enough to use the phone.” She does better with this now. To obtain a phone number, she said that she would call another friend who might have it or would use the yellow pages. Her family, especially her mother-in-law, takes care of her food shopping. She said that she went with her mother-in-law once but became very anxious. At the end of May, Ms. P. still spoke of her struggle with completing housework. She said that her mother-in-law and her husband do most of the household chores. Ms. P.’s grooming and hygiene are usually good except when she is symptomatic. She is able to handle her own finances. She has never been to the post office. Generally, her family or friends provide transportation for her to her appointments or on other outings.

Socially, Ms. P. is much more inhibited than she used to be. She generally stays inside watching television and said she “prefer[s] it.” She said that she becomes “a little uneasy” around “big crowds” and feels as though “people around me can tell I have an illness.” She becomes anxious if there are several people in her house. She said that her heart races and she takes “big gulps of air.” She said that she feels that she handles anger well, by expressing it verbally. Prior to her illness, she said, she was “outgoing.” This is no longer true. She participated in groups at the ADH but prefers individual time with others and in treatment.

Ms. P. often has difficulty persisting and pacing herself in the completion of tasks. She said that she finds it “really hard” to concentrate, but this has improved somewhat since her illness began. She finds that she “lose[s] her train of thought” easily, and this bothers her. She also finds that she has difficulty remembering “things that happened before I got ill.” When giving her history to the SSI Project Director, she had difficulty remembering dates. She said that she used to have a “drawing hobby,” but that she cannot do this anymore. She also enjoyed reading but finds this difficult because of problems with concentration and focus.

Ms. P. has not been employed since she was discharged from the Army in 9/97. Recently, she has been talking about working part-time but has not done so or attempted to do so.

**Summary**

Ms. P. is a 25-year-old, married woman who was first hospitalized approximately a week after she entered the Army, in August, 1997. Between August and December, 1997, she was hospitalized six times and had three episodes of treatment in a day hospital. Currently, she is involved with an intensive outpatient mental health team that provides treatment and case management services. She meets with her therapist twice a week. With this intensive support, Ms. P. has been able to remain out of the hospital. She is easily stressed, becomes anxious and, less often, experiences a recurrence of psychotic symptoms. She worries a great deal about managing her illness and getting back to “normal.” In addition, she feels stressed in her marital relationship and worries about the finances. Currently, Ms. P. is waiting for placement in a psychiatric rehabilitation day program. This would assist her in providing some structure to her day as, right now, she spends most of the day alone, watching television.

Ms. P.’s illness has been severe and disabling, and she is unable to work.

If you have any questions, please contact Ms. Perret at 410-328-1406 or Dr. Billingsley at 410-555-5555.

Sincerely,

Yvonne M. Perret, LCSW-C  
Project Director

John Billingsley, M.D.  
Psychiatrist

## LETTER 10

May 1, 2001  
Ms. Freida Johnson  
Disability Determination Services  
P.O.Box 7373  
Fair Chance, MD 21643-7373

Re: L. W.  
DOB:  
SSN:

Dear Ms. Johnson:

Mr. L. W. is a 26-year-old, single, African-American male who has a history of psychiatric hospitalization dating back to 1992. Mr. W. is a tall (6'1") man of slim build. He has cognitive limitations; for example, he could not find his way back to the SSI Project office even though he had been there twice before. He has difficulty keeping appointments and needed a great deal of outreach to maintain contact and to stay in treatment. He is a poor historian and is quite vague. He appears to be attempting to provide information, but his recall is poor.

When first interviewed by the SSI Project Director, Mr. W. presented with a strong body odor. He was ill-kempt. His speech was rambling and frequently non-responsive to the question. When asked about his mother, he began to cry. He spoke over and over about "not being able to go on" this way. He could not guarantee that he would be able to keep himself safe. Therefore, the Project Director walked him over to Babylon Psychiatric Crisis Center for evaluation. From there, he was admitted psychiatrically.

...

### Functional Information

In general, Mr. W. said, most of the time he is up and walking around. He sometimes stays at a mission, sometimes at relatives, and sometimes on the street. For a short period of time, he was living at the Safe Haven, a transitional housing program. Typically, he usually misses breakfast and sometimes eats lunch at the soup kitchens, mostly at Our Daily Bread. He is out most of the day. Mr. W. tends to present his functional ability as more capable than observations note.

Functionally, Mr. W. exhibits significant impairment in most areas. He states that he can cook and names rice and frozen patties as things that he can cook. He is able to use the telephone and could look up a phone number in the yellow pages. He said that he doesn't eat much and would likely need help shopping for food and other items. He believes that he can keep things clean. However, he has never had his own place to live and his appearance is not clean. Although he states that he makes sure he's clean, he had a strong body odor on several occasions when seen by the SSI Project staff, and his clothes are often quite dirty. He is unkempt as well. He said that he obtains clothing from the shelters. He describes his psychiatric symptoms in terms of "stress," which affects his ability to take care of his personal needs. He needs a representative payee to handle his presumptive SSI benefits and does not manage money well at all independently. Although he states that he can ride the bus, he does so only on routes that he knows and has difficulty finding new places. As was mentioned, he has been homeless for some time and has never maintained his own independent housing but rather has relied on family and shelters to house him.

Socially, Mr. W. has troubled relationships and has no friends. His relationship with his mother is conflicted as is his relationship with his sister. He notes himself that he has no "long-term" friends. When angered, he claims that he will face the problem and tell others what he didn't like. However, as recently as last year, he faced an assault charge for hitting his brother in anger. He frequently experiences psychotic symptoms that contribute to very difficult interactions with others. His representation of managing his behavior is not accurate.

Frequently, Mr. W. does not answer the question asked of him, i.e., his response is not appropriate for the question. For example, when asked about his concentration, he said it was "very good" and used as an example the following: "I was up on Pennsylvania Ave. A guy came upon me. I said please don't do anything to me. I was real scared. I begged him so he left. I believe in honesty." His memory is grossly intact but he has difficulty reporting dates and is vague about his history. He said that he likes "conversating" with others, but his conversation is frequently difficult to follow.

Mr. W. has been unable to sustain any employment for a significant period of time. His primary work history consists of temporary agency placements, and these were generally brief.

**Summary**

Mr. L. W. is a 26-year-old single male who has a history of psychiatric hospitalization dating back to 1992. Early on in his psychiatric treatment history, he was diagnosed with neuroleptic malignancy syndrome, thus making subsequent treatment difficult. In addition, in the last few years, he has begun abusing marijuana and cocaine, stating that the cocaine helps take the “stress off my mind.” Mr. W. has been intermittently homeless for a long period of time. His homelessness, poor interpersonal skills, use of cocaine and marijuana to treat his symptoms, and his dependence on his family have made any semblance of effective independent functioning impossible. He has maintained no steady relationships nor stable living. He has had a lengthy history of psychotic symptoms, violent acting out, lack of compliance with consistent outpatient treatment, and poor management of his life. Mr. W. clearly has schizophrenia. His family has tried to assist him, but they have found him to be very difficult to have in their homes given his assaultive and psychotic behavior. At the present time, Mr. W. is receiving services from the UMMS PACT team, an intensive, mobile outreach team for adults with serious and persistent mental illness. This team is reserved for individuals who have been non-responsive to conventional treatment.

Mr. W. has very limited employment history. He is clearly disabled and unable to work.

If you have any questions, please call Ms. Rothschild at 410-328-1406 or Dr. Brown at 410-328-2564.

Sincerely,

Maria M. Rothschild, LCSW-C  
Program Director

Francis Brown, M.D.  
Psychiatrist, PACT